Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Thursday 5 November 2026

Time: 12.30 pm - 3.00 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

05/11/2026 12:30 - 15:00

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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 3RD SEPTEMBER 2026

Present:	Dr M Beaman	Chairman
	Mr J Teape	Chief Executive
	Mr J Corrigan	Chief Finance Officer
	Dr K Cox	Non-Executive Director
	Mrs E Edwards-Smith	Non-Executive Director
	Mr A Ghadiali	Non-Executive Director
	Mr M Greaves	Non-Executive Director
	Mr A Griffiths	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Mrs N McMinn	Chief Nursing Officer
	Ms J Piper	Chief People Officer
	Mr P Richards	Non-Executive Director (part)
	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:

Mr A Atkinson	Care Quality Commission	Ms A Bance	Care Quality Commission
Mr J Buckley	Clinical Trials Manager (for item 95/09/26)	Mr H Davies	Cinapsis
Ms L Densham	Lead Governor	Mrs E Engelmann	Governor
Mrs S Fox	Corporate Governance Manager	Mrs B Gover	Patient Story (for item 95/09/26)
Mr D Gover	Patient Story (for item 95/09/26)	Mrs A Hall	Member of the Public
Ms J Harris	Director of Communications	Ms T Jeffery	Oncology Senior Research Nurse (for item 95/09/26)
Mr M Joyce	Governor	Dr A Lydon	Oncology Consultant (for item 95/09/26)
Mr J Nutley	Governor	Ms T Parker	Oncology Research Team Leader (for item 95/09/26)
Ms C Parnell	Chief of Staff	Ms J Rice	Office of Martin Wrigley MP
Mr M Taylor	Cinapsis	Mr M Tyrell-Smith	Member of the Public
Mr G Yardey	Governor		

	WELCOME AND INTRODUCTIONS
92/09/26	MB welcomed everyone to the meeting, in particular Karen Cox to her first meeting as a Non-Executive Director and Andrew Atkinson and Amy Bance from the Care Quality Commission. It was noted that six questions had been submitted in advance of the Board meeting. Three were in respect of material inaccuracies and misinformation circulating in the public domain; one around how the Trust was strengthening engagement with governors and members of the public; and two from Steve Darling MP in respect of the implications of changes in mental health and NHS Devon's future commissioning and service delivery arrangements. All questions would either be answered during the course of the meeting or at the end if there was time. They would also be posted on the Trust's website within 24 hours of the close of the meeting.
	PRELIMINARY MATTERS
93/09/26	**Apologies for Absence, Quoracy and Declarations of Interest** No apologies for absence had been received and the meeting was noted as being quorate. CS informed the Board that he had joined Delt Shared Services as a Non-Executive Director and would be taking over as Chair in February 2027. Delt was co-owned by Plymouth City Council, North Somerset Council and Devon ICB.
94/09/26	**Unconfirmed Minutes of the Meeting held on 2nd July 2026** The Board received the minutes of the meeting held on 2nd July 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 2nd July 2026 as a true and correct record.**
95/09/26	**Patient Story** The patient story concerned Mr Gover who had been diagnosed with prostate cancer and had been invited to take part in a clinical trial. • Over the past few years an effort had been made by the Trust to enter the commercial trial arena with a view that patients in the South West should have access to the same trials as those in bigger cites or abroad. • More than 52,000 men were diagnosed annually in the UK with prostate cancer and at present the usual form of treatment was chemotherapy, with the recognised side effects. • The clinical trial aimed to introduce, through injection, the treatment into the cancer cell, leaving healthy cells untouched. This meant patients did not experience the side effects normally associated with chemotherapy. The Trust was the first site in the country to be involved in the trial. • There were currently 923 patients from the Trust participating in research with 22 departments involved in research. • Mr Gover explained that he was from North Devon and had found the chemotherapy he received difficult to manage due to the side effects. The trial drug had not had any negative impact on him. The cost of travel to Torbay

Hospital for the treatment was included as part of the trial. Mr Gover added that the staff who were caring for him were excellent.

- Mr Gover was asked if there was anything the Trust could have done better for him. Mr Gover replied that that there had been delays getting the drugs ready as they were made up of 11 vials, however this was a minor point.
- The intention of the treatment was queried. It was noted that it was hoped it would extend life and have less side effects than chemotherapy. From a demand point of view, it would also reduce the number of unplanned admissions to the Trust due to patients presenting with chemotherapy side effects.
- The move to providing treatment in neighbourhoods was discussed and whether there was a view treatment such as this could be provided in communities. It was noted that this was the case for treatments such as immunotherapy.
- The need to ensure staff and patients were aware of clinical trials was discussed, noting that there was a network of cancer services in Devon.
- An initiative would be rolled out in mid-October across the South West peninsula to ensure all appropriate patients were considered for clinical trials.
- The need to encourage patients and families to ask to take part in research was discussed, and how this could be realised. It was noted that this would be achieved through more visibility, for example posters in wating rooms and staff informing patients of the trials that were available.

The Board thanked Mr Gover and the research team for presenting the Patient Story.

96/09/26 **Report from the Chairman**

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

- He had conduced visits to the Catering team; Oncology team; Podiatry Department at Castle Circus Health Centre; and met with Staff Network Chairs; Trust's Director of Capital Developments and Chair of South West Ambulance Foundation Trust. In addition, meetings had been held with both Caroline Voden and Steve Darling MPs.
- MB had attended a national meeting in respect of the Amos and Ockenden reviews.
- Jo Webber had formally taken over from MB as the lead NED for maternity safety.
- A visit to Allerton Ward had taken place after a successful evacuation had been managed following a fire alarm due to a faulty piece of equipment.
- A discussion had been held with the senior multi-professional educational lead for NHS England around the relationship between areas of educational concerns and patient safety concerns.

The Board received and noted the Chairman's report.

97/09/26 **Chief Executive's Report**

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

- JT referenced the section in his report around investing in the future of health and care research, and he suggested an action to consider how the Board had oversight of research and development that would need to be picked up. **Action: KL**
- The Trust had launched its Listening to our Communities website to support responses to questions from staff, patients and governors. It would continually be updated with topical issues to provide clear evidence-based responses.
- The information pack included a report on Mortuary, noting Trusts had received a letter from NHSE's Chief Nursing and Chief Operating Officers requesting that Boards had oversight and reviewed their board arrangements. This work had taken place at the Quality and People Committee noting that the Trust was compliant with 32 of 39 recommendations, with seven requiring further action but with mitigations in place.
- The Trust had been required by the Human Tissue Authority to review incidents and near misses over the last 11 years against current criteria. Assurance was provided that this work had been completed.
- A query was raised around the Trust's readiness for increased attention following the transfer of Adult Social Care back to the local authority. It was noted that a transition escalation plan and framework were in place and as part of that a robust communications plan with stakeholders would be agreed. It was agreed the plan would be presented to the Board once finalised. **Action: JT**
- The impact to the Trust of the closure of maternity services in North Devon was queried. It was noted that the Trust had been asked to provide mutual support if required, and had been asked to support two referrals from Royal Devon University Hospital (RDUH)

The Board noted the report of the Chief Executive and endorsed the work to deliver the recommendations in respect of Mortuary services following receipt of a letter from NHSE's Chief Nurse and Operating Officers.

98/09/26 **Board Assurance Framework and Corporate Risk Register**

The Board received the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), circulated with the agenda pack. The following was discussed:

- The BAF was the fifth and CRR second iteration of the documents presented to the Board. No material changes had been made to them or the Trust's strategic risk profile in the last month.
- All risks had now been successfully transferred from the legacy Datix system to DCIQ.
- It was recognised that the Trust's risk maturity was beginning to strengthen. The next stage of the Trust's maturity was to undertake some deep dives to provide assurance that all the of the Trust's corporate risks were visible to Committees and the Board.

- It was recommended the Board took limited assurance as the new risk management framework was not yet fully embedded.
- A query was raised around when it was expected maturity would be achieved. CP explained that it was hoped this would be in the next two months.
- There were five sections of the BAF that had inadequate assurance and three in the CRR where risk had increased over the past couple of months. Assurance was sought that work was taking place to improve these positions in respect of delivery improvement and increasing CRR scores in respect of clinical safety and patient experience.
- JT explained the Trust was currently in a very challenging position in respect of performance and financial risk. Assurance was provided that plans were in place to improve the position, but it was not yet clear what was driving some of the underlying demand issues.
- Concern was raised around the confidence that those actions detailed in the BAF with delivery of dates in Quarter Two would be delivered. CP explained that the BAF and CRR were reviewed on a monthly basis by executive leads and the narrative attached to actions would be updated if any factors were impacting on delivery timescales, and escalated through the Trust's governance structures.
- It was suggested it would be helpful for the heat maps included in the CRR to provide trend information. CP explained that at present there was not enough information to provide a trend analysis, but it would be provided once more information was available.
- Given the conversations already held in the Public Board, and those at Private Board earlier in the day, it was suggested the Board could consider a higher risk appetite in respect of transformation, which was currently moderate.

The Board received and noted the Board Assurance Framework and Corporate Risk Register.

TO APPROVE

99/09/26 **Constitutional Arrangements and Building on Governor Experience**

The Board received the Constitutional Arrangements and Building on Governor Experience Report, circulated with the agenda pack. The following was discussed:

- CP explained the report proposed a number of updates to the Trust's Constitution to ensure it was aligned to the Health Bill when it was passed.
- The changes provided the Trust with a formal framework around the removal of governors and their statutory responsibilities and would only be enacted when the Health Bill was passed.
- Other amendments reflected the removal of the Children and Family Health staff group, as the Trust no longer had responsibility for this group of staff. It also proposed removing all the other staff groups and introducing a single staff constituency to remove the need for elections for staff governors if the Trust's operational framework changed in the future.
- As part of this work with the Trust would be working with its Governors to shape how the Trust would engage with its population following the enaction of the Health Bill.

- Thanks were placed on record to the Trust's Lead Governor for her support throughout this process.

The Board:

- **approved the enabling amendment to the Constitution set out in Appendix One to the report, noting that it would take effect only if the relevant legislative provisions were enacted and commenced;**
- **approved 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 to the report; and**
- **endorsed an inclusive co-design process, involving governors, service users, carers, staff, community representatives and partners, to develop future arrangements for public accountability and engagement.**

100/09/26 **Minimum Standards of Patient Experience for Elective Care**

The Board received the Minimum Standards of Patient Experience for Elective Care Report , circulated with the agenda pack. The following was discussed:

- The report set out the Trust's position in respect of NHSE's minimum standards of patient experience for elective care, ie support provided to patients once accepted onto an elective pathway.
- The current position was limited assurance with relevant programmes underway and examples of good practice, however the Trust could not evidence consistent compliance across all specialties.
- A base line assessment to be undertaken was proposed, alongside a delivery plan, the results of which would be presented to the Board at its meeting in January.
- It was recognised that, disappointingly, the Trust was not providing the level of communication to its patients that it would aspire to deliver, noting that this issue was something that had also been pursued by the Council of Governors.
- It was suggested there were some quick gains for the Trust around, for example, how the Trust's text service to patients was used.
- The engagement of speciality teams as part of this work was queried and also that the Trust appeared to be having to constantly respond to external requests, eg GIRFT, NHSE and did not appear to understand what was happening across the organisation.
- This view was acknowledged, work was taking place to reprioritise the workstreams and pause some, to provide space for delivery of the Trust's main priorities. It was noted that the minimum standards of care was not new to the Trust, but NHSE were now requiring Trusts to evidence that it was being delivered consistently. In relation to the GIRFT visit the Trust had asked GIRFT to support the Trust and provide some external expertise and challenge to support executives in encouraging teams towards the work they needed to undertake to improve performance.
- It was suggested it would also be helpful to understand the reason for the Trust longest waiters, for example it could be due to personal choice rather than operational issues. In addition it was suggested there needed to be a

more balanced view of experience and outcomes vs access and performance.

- It was recognised that the Trust could draw on learning from other parts of the NHS and beyond to support its work.

The Board:

- **received limited assurance;**
- **approved the Trust wide baseline assessment and delivery plan;**
- **endorsed standard patient communications, accessible alternatives and clear communication routes when a patient was deteriorating;**
- **agreed quarterly oversight through the Quality and People Committee; and**
- **requested a further report in January 2027 containing the completed baseline, key risks, delivery milestones, assurance dashboard and draft public statement.**

FOR REVIEW

101/09/26 **Our Plan for Better Care**

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

- As previously reported, work was taking place to prioritise the workstreams as part of the Our Plan for Better Care: Adult Social Care transition; UEC improvement; RTT delivery; statutory work focusing on the Tower Block; financial delivery including workforce; and Epic stabilisation and recovery.
- A query was raised around whether the Trust had sufficient capacity, especially given increasing demands related to the Adult Social Care transition; CIP delivery and current inaccurate Epic data. ST stated that the executive team would have wished to have made more progress, but it was difficult when managing many competing priorities. ST provided reassurance that capacity and capability had been strengthened in some areas, for example the appointment of a dedicated Adult Social Care Transition Director. The Finance team also had the support of a member of staff from NHSE.
- In respect of current performance against the Our Plan for Better Care domains, it was suggested that delivery of some of them would reduce pressure on attendances etc so it was not felt that all of them could be abandoned. JT stated that they were not being abandoned but paused and that some would become parts of other pieces of work for example pathway review as part of Urgent and Emergency Care.

  How engaged the Trust's workforce was with the Our Plan for Better Care was queried. It was recognised that members of staff who were involved in delivering parts of the workplan would be aware of it, and able to link to back to the Trust's Strategy, but it was not necessary for them to be aware of the overall programme of work. It was suggested there was a need to have an embedded quality improvement approach across the Trust's workforce and this could be discussed at a later meeting. **The Board:**
- **noted the report and progress made during the reporting period;**

- **acknowledged the risks to delivery and ongoing work required to improve the Trust's risk position; and**
- **took assurance that the transformation programme was executively owned and work was being undertaken to evidence impact to the organisation's key priorities.**

102/09/26 **Torbay Hospital Tower Block – Fire Safety Improvement Programme**

The Board received the Torbay Hospital Tower Block – Fire Safety Improvement Programme Report, circulated with the agenda pack. The following was discussed:

- The Board was reminded that the Trust currently managed its business in a number of very old buildings, both on the acute site and in the community, and there was a challenge to ensure they were in line with modern-day healthcare standards.
- The Tower Block was one of the oldest buildings in the Trust's estate portfolio and had been due to be replaced by the NHP until the programme was delayed with a potential start time of 2034.
- Given the Tower Block did not meet current building standards there was therefore a need to act, to manage risks associated with an older building.
- The report presented to the Board was clear about the issues facing the Trust in terms of the Tower Block and articulated the work that had taken place around a fire safety programme. The work aimed to provide assurance to the Board that the Tower Block was being made as safe as possible in respect of risk of fire. Assurance was provided that this work had been undertaken with advice obtained from external fire experts and the Fire Brigade.
- It was recognised that alongside this work, the Board needed to continue to lobby for funding to replace its ageing buildings in line with the plans that were submitted to the national NHP team. **Action: JT**

The Board:

- **took limited assurance that the Trust had strengthened fire safety governance, operational controls, staff preparedness, evacuation planning, patient dependency monitoring and regulatory engagement through the Tower Block Fire Safety Improvement Programme;**
- **noted that, while strengthened controls and mitigation measures were now in place, the age, configuration and clinical use of the Tower Block meant that ongoing management of fire safety risk and further estate investment remained necessary; and**
- **supported the continuation of executive oversight, regulatory engagement and capital planning arrangements to ensure risks continued to be reduced as far as reasonably practicable whilst longer-term solutions were progressed.**

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

103/09/26 **Finance and Operations Committee**

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

Alert:

- The Committee had refocused its immediate work on the following: Urgent and Emergency Care (UEC); Referral to Treatment Times (RTT); and CIP, to identify what was driving the Trust's poor performance and what was being done to deliver improvements.
- The EPIC data quality analysis was now complete and had found that, due to incoherence across many aged systems and the application of business rules, the Trust's true RTT had been masked, which was c3% lower than reported.
- The need for productivity improvements to support delivery of in year plans. The Committee would be scrutinising the top RTT delivery plans identified by executives.
- Planning for 2027/28 had commenced and the Committee would be scrutinising strategic assumptions as plans were developed.

Advise:

- A regional red flag dashboard had been introduced to monitor the financial performance of trusts in the region.
- The Committee's scrutiny of the Devon Procurement System approach to, and use of waivers, had been deferred to the September meeting.

Celebrate:

- The Committee noted how the executive team had invited and embraced external support to guide focus on in year improvement opportunities.

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

104/09/26 **Operational Performance Report**

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

- The UEC recovery plan had been submitted to Region and shared with the Board.
- Weekly oversight sessions would be taking place, focusing on the four pillars; unscheduled care village; implementation of the same day emergency care plans; and reduction of long waits.
- The drivers impacting on the Trust's RTT performance were now understood, which resulted in a larger challenge than anticipated, but the Trust remained committed to meeting its end of year targets.
- There remained some areas of under-delivery post-Epic, with additional resource being provided to support improvements.
- Areas of concern included cancer, however diagnostic performance had been slowly improving.

The Board noted the following assurance ratings:

- **UEC 4 Hour Performance - Limited**
- **UEC Ambulance Handover - Limited**
- **UEC 12 Hour Performance - Limited**

- **RTT 65-week waiters - Limited**
- **RTT 18 week waiters - Limited**
- **RTT 52-week total waiting list size, % first appointment – Limited**

105/09/26 **Monthly Finance Report**

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

- There were several risks that could impact on delivery of the end of year forecast including Adult Social Care; income related to the delivery of patient care; and delivery of recurrent CIP. Work was taking place to reforecast CIP delivery plans to understand the recurrent gap.
- Work was taking place with the Epic team to ensure coding was correct and all income captured.
- A query was raised around confidence that the recurrent CIP target would be delivered. JC explained that the current forecast suggested the planned recurrent CIP would not be delivered, but work would take place to ensure it was maximised.
- It was acknowledged that this year's plan had been very ambitious and had a significant amount of risk attached to it.
- Planning for 2027/28 had already commenced with a framework in place to support the planning process.

The Board agreed 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.

106/09/26 **Electronic Patient Record (EPR) Status Report**

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

Epic implementation had now moved to the business as usual stage with responsibility being handed over from the EPR Board to Chief Executive leads.

The Board noted that moderate assurance was provided on EPR progress.

107/09/26 **Quality and People Committee**

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

Alert:

- The Committee raised concern around the slow progress being made to deliver the Internal Audit action plan in respect of sexual safety. A further update would be provided to the October meeting.
- A verbal update had been provided on the Multiple Sclerosis service which remained in a vulnerable position with a considerable backlog of patients waiting for review. These were being seen on a prioritisation basis, and no significant harm had been identified to those waiting. A recovery plan was in place and progress on this would be shared with the Committee. In addition, a paper would be presented to the Committee around the sustainability of other single-handed specialities.

- There had been overspends across all care groups in month 4 and the Committee asked that the next Workforce Performance Report described the actions being undertaken to address reliance on temporary staffing.
- The Workforce Strategy was complete and would be shared with the Committee in September and Board in October.

Assure:

- Assurance was taken on the End of Year Safer staffing report with compliance against all 12 domains for safer staffing, governance and process. Work would be taking place with NHSE to look at unavailability and rostering.
- Moderate assurance was received around the Working Lives of Resident Doctors, with limited assurance in respect of annual leave compliance which was a new NHSE Standard, with a task and finish group in place to support delivery.

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

108/09/26 **Appraisal and Revalidation Report**

The Board received the Appraisal and Revalidation Report, circulated with the agenda pack. The following was discussed:

- There were currently 51 unapproved missed appraisals, 17 of which involved locally employed doctors who rotated and did not always work on a full-time basis.
- It had been identified that this cohort of doctors were not always aware of their statutory responsibility as doctors and were often with teams for a short period of time. Work continued to support these doctors, alongside additional support on a national basis which meant they were treated like doctors in training rather that locally employed doctors.
- Some doctors viewed appraisals as voluntary and they were being reminded that this was not the case.
- Specialities were having to be reminded that it was their responsibility to pay for the time required for appraisers to ensure appraisals for doctors within their team, and this was an ongoing challenge.
- The Board noted that it was being asked to approve a submission to the national team in terms of appraisals that stated financial restrictions in the Trust caused the appraisal team difficulties. It was agreed this statement would be amended as financial difficulties should not impact the Trust delivering a statutory role. **Action: KL**
- A query was raised around revalidation and appraisals. It was noted that an appraisal could be deferred, for example for ill health or, if necessary, a non-engagement request could be submitted, however additional reminders were being sent to consultants to remind them of the requirement. If non-engagement continued, KL could write to the GMC to explain that all the resources had been provided to enable a consultant to undertake their appraisals, but it had still not taken place.
- The appraisal rate of consultants was similar to that for other staff.

The Board:

- **noted the contents of the report;**
- **took satisfactory assurance regarding appraisal and revalidation arrangements;**
- **noted the risks relating to appraiser capacity, missed appraisals and oversight of locally employed and locum doctor; and**
- **supported the proposed actions to strengthen appraisal resilience and quality assurance arrangements.**

109/09/26 **Working Lives of Resident Doctors**

The Board received the Working Lives of Resident Doctors, circulated with the agenda pack, noting it comprised reports on the 10 Point Plan; Post Graduate Medical Education Quality Assurance Annual Report 2025/26; and Guardian of Safe Working Hours Report.

The Board:

- **received and noted the integrated resident doctor workforce and education report;**
- **agreed the overall assurance rating of moderate, recognising limited assurance for annual leave compliance and safe working hours/rota resilience;**
- **noted the continuing high volume of exception reports in the August Guardian of Safe Working Hours dataset, with 176 reports supplied for this reporting period;**
- **noted the recurrent exception-reporting hotspots, including speciality, grade, outcome and ward-level themes from the August Guardian of Safe Working Hours appendix, and that plans were in place at speciality level to review and support; and**
- **supported the annual leave task and finish group to deliver compliance with NHS England minimum standards before August 2027.**

110/09/26 **Perinatal Quality and Safety Report**

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

- MB was thanked for his role as the Trust's NED Maternity Lead – this role was being taken over by JW.
- The Board was reminded that, following a birthrate plus establishment review a small uplift in the midwifery workforce was required. The business case for the uplift had now been approved.
- A lot of work had taken place around cultural leadership and a psychological safety strategy within the perinatal service had been developed.
- The improved governance framework was in place and in the process of being rolled out.
- There had been a focus on training and since the paper had been written training compliance had improved.
- Since the last meeting two national reports had been published: Amos and the report into Nottingham Trust. An extraordinary board meeting was being

held on the 17th September to sign off the Trust's compliance statement against the 10 Point Plan.

- Maternity was no longer receiving targeted support and had been removed from the improvement programme and was now subject to routine monitoring.
- The interaction between medical professional and nurses as part of maternity teams was raised, noting that KL would be accompanying NM to regional and national meetings later in the year.
- The work of the Trust's maternity and perinatal leadership team was recognised, noting a risk for the service around neonates was one of capacity.

The Board received the report, noted the progress and risks described, and took satisfactory assurance that maternity and neonatal safety, quality and governance arrangements were in place and continued to be strengthened. The Board also noted the areas requiring continued oversight, particularly training recovery, workforce fragility, data quality, neonatal capacity constraints, and delivery of Maternity Incentive Scheme Year 8 requirements.

111/09/26 **NHSE End of Year Safe Staffing Report**

The Board received the NHSE End of Year Safe Staffing Report, circulated with the agenda pack.

The Board noted the NHS England findings, took significant assurance from the external review and endorsed completion of the identified actions through the established safer staffing and workforce governance arrangements.

CLOSING MATTERS

112/09/26 **Any Other Business and Review of Meeting**

Committee Chairs' Reports

Committee Chairs were asked to consider if they felt, now that it had been running for some time, if there were any improvements that could be made to the Committee Chairs reports or presentations to the Board.

113/09/26 **Board Assurance Framework (matters for review or escalation)**

No issues were discussed.

114/09/26 **Board Workplan**

The Board received and noted the Board Workplan.

115/09/26 **Date and Time of Next Meeting:**

The next Board meeting in public is scheduled to take place at 12.30 pm, Thursday 5th November 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. **September Update:** due to issues with data capture in Epic it was not yet possible to provide this information.	**Open**
97/09/26	**Chief Executive's Report:** To work with R and D team to ensure board reporting is in line with the recently published NHS England » Framework for NHS boards: monitoring research activity (published 26th August 2026).	**KL**	**October Update:** KL has asked for a board report in line with these recommendations to QPC and Board in Nov 2026. **November Update:** suggestion it is more appropriate for a Board discussion. Paper in preparation and will be presented to either November or December Board.	**Open**
97/09/26	**Chief Executive's Report:** Once ready, ASC transfer communications plan to be presented to the Board.	**JT**	**November Update:** This relates to the Board Development session held on 26 September. The discussion will be written up, and a document will come back to the Board in November. **Propose close action**	**Open**
102/09/26	**Torbay Hospital Tower Block – Fire Safety Improvement Programme:** continue to lobby the national team for funding to replace ageing buildings.	**JT**	**October Update:** work continues on this including ongoing discussions regarding ward block replacement due to associated fire safety issues and ongoing dialogue with New Hospital Programme. **November Update**: Additional funding of £8m now confirmed. New Hospital programme round table held with national team including NHSE and ICB 9/10/26.	**Open**

108/09/26	**Appraisal and Revalidation Report:** amend statement in submission to national team around to provide assurance that financial restrictions did not impact on the delivery of appraisals.	**KL**	**October Update:** Completed **Propose close action.**	**Open**

Torbay and South Devon NHS Foundation Trust

Presented to:	Board of Directors					
Title of Report	Chief Executive Officer's report					
Date of Meeting	05.11.2026		**Author**	Laura Patrick, Head of Communications and Engagement; Jane Harris, Director of Communications		
Executive Lead	Joe Teape, Chief Executive		**Executive Sign Off**	29.10.2026		
Governance Route						
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
				X	X	
Executive Summary	This report provides the Board of Directors Board with assurance on the handling of sensitive, confidential and/or complex issues that affect our ability to achieve our vision and purpose.					
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**
						X
How this paper supports delivery of the Strategy	The paper supports delivery of the Strategy by providing Board oversight of the principal issues affecting strategic delivery, including operational and financial recovery, safe and sustainable services, workforce resilience, estate modernisation, integrated care and effective partnership working.					

Board Assurance			
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
BAF-LG	Leadership and Governance	2x4=8	The paper provides additional assurance by keeping the Board sighted on significant strategic, operational, regulatory and reputational matters, together with the governance and mitigation arrangements in place. It supports effective oversight and informed decision-making but does not change the current BAF risk score

Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
					X

Torbay and South Devon NHS Foundation Trust

Compliance / Regulatory Requirements	The paper supports the Board in discharging its statutory and regulatory duties, including oversight of quality and safety, financial governance, fire safety, information governance, equality, consultation and engagement requirements, and compliance with NHS England and CQC expectations. It highlights material areas of regulatory risk and the actions being taken; individual matters remain subject to their relevant legal, governance and assurance processes.			
Ethical or EDI implications?	The paper has potentially significant ethical and EDI implications. All items described must ensure they are transparent and evidence-based, with proportionate equality impact assessment and meaningful engagement where applicable.			
Assurance rating	Significant	Moderate	Limited	Inadequate
		X		
Assurance rationale	Moderate assurance is provided because the report gives the Board broad visibility of significant strategic, operational, safety, financial, regulatory and reputational matters, together with the governance arrangements and actions in progress. However, several issues remain developing, high risk or dependent on further evidence, decisions and delivery; therefore, the report supports oversight but does not provide full assurance that all risks are controlled or outcomes secured at the time of presentation.			
Appendices	Appendix A – Let's talk neighbourhood health services colleague insight report Appendix B – Shaping future neighbourhood health services: feedback from senior medical colleagues			

Torbay and South Devon NHS Foundation Trust

Chief Executive's report

Chief Executive Officer issues

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, colleagues have continued to be open with me about the pressures they are experiencing and the things that make their jobs harder. What has also come through strongly is their determination to improve things for the people we care for and for each other.

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 Castle Circus Health Centre, Dartmouth 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 co-hosted our Annual Members Meeting at Paignton Library. I particularly valued the opportunity to talk directly with members of the public and hear their views and experiences first-hand. Those conversations are an important reminder of why it matters that we continue to listen and remain connected to the communities we serve.

5. Our Learning Culture Roadshows have given me another important opportunity to hear directly from colleagues about their experience of working here. I have been struck both by the honesty of those conversations and by how much people want to be part of making things better. Over the past two months I have joined roadshows/ walk abouts at Torbay Hospital, Newton Abbot Hospital, Dartmouth Health and Wellbeing Centre and Totnes Hospital.

6. I had great pleasure in joining the ribbon cutting for the new Bay of Wonders mural in our children's eye clinic waiting area at Torbay Hospital (funded by a legacy to our Torbay and South Devon NHS Charity). I also enjoyed spending time with colleagues in our theatres, gardens and grounds and OMFS service.

7. I was also pleased to be invited, along with Kate, our Chief Medical Officer, to speak at our Medical Staffing Committee's Annual General Meeting where we had a good conversation about the future of health and care services in Torbay and South Devon. We have passionate, committed and diverse senior clinicians who are intensely knowledgeable about the needs of the communities we serve and I really value their insight, challenge and support.

8. I have continued to meet regularly with pathology colleagues across histopathology (cellular pathology) blood sciences and microbiology, along with fellow executives and senior leaders as we progress long-term solutions for our pathology service.

9. 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.

10. I appreciated joining the Chairs of our Leagues of Friends and colleagues from Torbay Hospital Nurses League for our regular quarterly meeting and I was also delighted to be asked to speak at Volunteering in Health's Annual General Meeting in Teignmouth. We are incredibly fortunate to have such committed voluntary and community organisations and volunteers across Torbay and South Devon, giving their time, energy and care to support local people and communities and I am sincerely grateful for the way they work so collaboratively with our services.

Leadership updates

11. This is Paul Richards' final Board meeting before he leaves us after nine years as a Non-Executive Director, including his time as our Senior Independent Director. During that time, Paul has made a significant contribution to our organisation and the wider NHS, through his leadership of our finance and performance committees and his longstanding championing of our digital ambitions and the Electronic Patient Record programme.

12. On a personal level Paul has been an incredible supporter of Torbay and South Devon and has consistently advocated for the population we serve as well as being an immensely valuable source of advice to us all on a wide range of issues. He has brought exceptional experience and insight to our Board discussions as well as constructive challenge for us to improve what we do for the population we serve. On a personal level he has consistently been available for advice during my time as Chief Executive and we will miss him greatly.

Planning 2026/27 & NHS England Oversight

13. The Executive team attended our mid-year review with NHS England colleagues on 02 October 2026. This meeting was also attended by colleagues from NHS Devon Integrated Care Board.

14. The purpose of the meeting was to review progress against the agreed 2026/27 plan and trajectories, including recovery trajectories, and to determine whether there was sufficient assurance of delivery for the remainder of the year.

15. We provided assurance to NHS England in the following areas:

    - improvement in urgent and emergency care performance during September, including a substantial improvement in both all-types and Type 1 performance despite high levels of demand

- implementation of the Unscheduled Care Village from 15 October
- delivery of the diagnostic plan, with performance on trajectory for the previous three months and recovery expected to continue
- continued commitment to the revised Referral to Treatment and 52-week recovery objectives
- delivery of the financial plan at month six, with the Trust maintaining a break-even year end objective and no immediate cash concern
- alignment between the Trust and ICB on the activity-based Elective Recovery Fund position
- integration of the urgent and emergency care and winter plans, including arrangements for vaccination, infection prevention and discharge
- governance arrangements for quality, equality impact assessment and maternity improvement.

16. The meeting identified the following areas where further assurance is required:

- the urgent implementation plan needed to respond safely to the Fire and Rescue Service enforcement notice
- identification and commissioning of sufficient alternative system capacity, including mental health, step-down, community and end-of-life provision, to mitigate the Tower Block occupancy reduction
- delivery of the revised month-by-month RTT recovery trajectory following the Epic implementation
- the sustainability of MRI capacity
- resolution of system dependencies affecting urgent and emergency care, including ambulance call-before-convey arrangements, 111 conversion rates, mental health demand and primary care access
- delivery of the financial plan
- risks associated with the transfer of adult social care responsibilities to Torbay Council and the future continuing healthcare model
- completion and financial quantification of the maternity ten-point plan.

17. The Regional Executive Team wrote to us on 28 October 2026 confirming partial assurance and outlining actions and next steps. The actions identified and

required will be overseen through existing oversight and programme arrangements.

Segmentation and League Table publication

18. On Thursday 10 September 2026, NHS England has published the Quarter 1 2026/27 NHS Oversight Framework segmentation and league tables for NHS providers.

19. The NHS Oversight Framework brings together a range of measures covering operational and financial performance. Trusts are assigned to one of four segments, which help determine the level of oversight and improvement support provided by NHS England. League tables rank providers nationally against organisations of the same type.

20. We have been placed in Segment 3. For Q4 2025/26 we were placed in Segment 4.

21. Our position in the acute and specialist trust league table is joint 101st out of 134 trusts, compared with 102nd in the previous publication.

22. NHS England has advised that comparisons with previous publications should be treated with caution. For 2026/27, the framework has been revised, including changes to the metrics used and a move from a system based on relative quartiles to fixed national thresholds. This means a change in segment does not necessarily indicate a significant change in organisational performance.

23. NHS England has described Q1 2026/27 as the baseline against which future performance will be assessed under the revised methodology.

24. The publication does not change our focus on improving services for people in Torbay and South Devon. We continue to work on reducing waits for care, improving urgent and emergency care performance, strengthening productivity and improving our financial position while delivering safe and compassionate care.

25. As in previous years, NHS England's financial override remains in place, meaning that organisations in financial deficit cannot be placed above Segment 3 regardless of performance in other areas.

26. Context provided by NHS England
    • Segmentation results should not be viewed in isolation or directly compared with previous results because of changes to both the methodology and metrics used.
    • The move from relative quartiles to fixed thresholds is intended to provide clearer and more consistent expectations for organisations and improve transparency.
    • League table positions should be interpreted alongside underlying performance data and local context. Small movements do not necessarily reflect a material change in performance.

• The purpose of the framework is to support transparency, accountability and improvement, rather than provide a definitive judgement on the quality of care provided by an organisation.

27. The data is available publicly through NHS England's Oversight Framework publication: 2026/27 Q1 segmentation results and public performance dashboard

Care Quality Commission inspection

28. The CQC undertook an unannounced focused inspection at Torbay Hospital on 23 and 24 September, covering surgery, critical care, end of life care and children and young people's services.

29. The visit formed part of its follow-up of previous findings and improvement plans.

30. Initial feedback recognised the quality of care and the professionalism and compassion of colleagues, while also identifying areas where further improvement is required.

31. We are addressing the initial feedback through our established governance arrangements and will provide a further update when the formal inspection process has concluded.

Proactive IR(ME)R inspection of Nuclear Medicine

32. We have been notified that our Nuclear Medicine service at Torbay Hospital will be inspected on 11 November as part of the proactive Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection programme.

33. The inspection will include observation of practice within the department, review of records and evidence, and discussions with clinical, operational, governance and medical physics colleagues. A range of information is also being provided to inspectors in advance, including procedures, governance arrangements, equipment information and radiation incident records.

Consultant industrial action

34. The British Medical Association (BMA) has announced 48 hours of strike action by consultants in England from 25 to 27 November, unless the dispute is resolved beforehand. Consultants are expected to provide Christmas Day levels of cover during the action. This would be the first consultant industrial action since 2023.

35. We are standing up our Patient Safety Industrial Action Committee to support our planning and will keep Board updated on any local implications as the position develops.

Governor elections

36. Five new public governors joined us on 01 October following this year's second governor elections:
    - Teignbridge: Ollie Abercombie and David Palethorpe
    - Torbay: Pat Harris and Jo Rice
    - South Hams: Jill Lawrence

37. This leaves one remaining public governor vacancy, representing the rest of the South West. Our new governors will take part in their induction on 09 November.

Medicine for Members: skin health and skin cancer

38. On 20 October I joined our latest Medicine for Members event, where Consultant Dermatologist Dr Rosie Davis spoke about skin health and skin cancer, including how people can protect their skin, recognise possible signs of skin cancer and know when to seek advice. This is particularly relevant locally, with South Devon experiencing high levels of UV exposure and particularly high rates of skin cancer.

39. As someone with fair skin and lots of freckles, the session had particular relevance for me and I came away with some useful tips about looking after my own skin. Judging by the questions and discussion on the day, I know many others did too.

40. Medicine for Members is hosted by our governors and gives local people the opportunity to hear directly from clinical experts and ask questions about health topics that matter to them. I would like to thank Rosie, our governors and everyone who joined us for the event.

Annual Members Meeting 2026

41. On 30 September we held our Annual Members' Meeting at Paignton Library. This was the first time we had taken the meeting away from the Torbay Hospital site, as part of a new approach intended to make it more accessible and connect the formal business of the meeting more closely with our communities.

42. The formal meeting provided an opportunity to reflect on the progress and challenges of 2025/26, present our annual report and accounts and hear the findings of our external auditors. Members of the public attended in person and online, and the questions raised covered digital access, patient experience, hospital services, pathology, the safety of the Tower Block and the future of health and care in Torbay and South Devon. All questions and responses were subsequently published on our website: https://www.torbayandsouthdevon.nhs.uk/about-us/get-involved/annual-members-meeting/

43. The meeting formed part of a wider community health and wellbeing event, bringing together our services, governors and partner organisations. The marketplace included 14 stalls offering health information, advice and opportunities for people to speak directly with teams, while small-group conversations gathered people's experiences and views to inform the development of neighbourhood health and care.

44. On a personal level it was great to reach outwards and hold this event in one of the communities that we serve and the atmosphere in the marketplace was vibrant. I really hope we can build on this going forward as we take our discussions more into all of our communities reflecting the way that we want to do our work, in an open and transparent way and close to those that we serve.

45. I would like to thank our governors, colleagues, partners and everyone who joined us and contributed to the discussions. We will build on the experience as we develop this approach and take future Annual Members' Meetings to other neighbourhoods across Torbay and South Devon.

Listening to our communities

46. We have updated our Listening to our communities webpage to add questions about the tower block and maternity services.

47. The page brings 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.

48. 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.

NHS England guidance on single-sex services and facilities

49. On 15 October, NHS England published new guidance to support NHS organisations in the provision of single-sex services and facilities. This includes revised guidance on privacy, dignity and safety in hospital accommodation and new guidance covering staff facilities. NHS England has asked chief executives and Boards to review the guidance at pace, ensure that local policies and practices are consistent with the law and national guidance, and put clear plans in place to address any changes required.

50. We had already established a multidisciplinary task and finish group, chaired by our Chief Medical Officer, Kate Lissett, to consider the implications of the Supreme Court judgment and prepare for the national guidance. The group brings together expertise in patient care, workforce, estates and facilities, inclusion, legal and information governance and communications.

51. Now that the national guidance has been published, our immediate priority is to understand our current estates position and identify where there may be challenges in meeting its requirements. This includes reviewing the facilities available to patients, staff and visitors across our estate. We will also let colleagues know that this work is under way.

52. Alongside this, the group is reviewing relevant patient and staff policies and developing an Equality Impact Assessment. This will help us understand the potential impact of any changes and inform how we implement the guidance consistently and with care.

53. Throughout this work, our focus will be on meeting our legal and national requirements while continuing to protect the privacy, dignity and safety of patients, colleagues and visitors. We will provide further assurance to Board as the work progresses.

Torbay and South Devon NHS Foundation Trust

Priority areas

Estate resilience, fire safety and emergency preparedness

54. The fire safety challenges in the Tower Block remain an important priority for us. There is a separate paper on today's agenda setting out the position in detail, including the action we are taking in response to the Fire Service and CQC, so I will not repeat that here.

55. As part of that work, we are making a number of temporary changes to where some services and teams are located, helping us to reduce occupancy in the Tower Block while maintaining services for our communities. I recognise that these changes affect colleagues and patients, and I am grateful to everyone who is helping us make them safely and with as little disruption as possible.

56. Alongside the immediate work, we have continued to be open with our colleagues, patients, local communities and partners about the challenges we face and the action we are taking. We are also continuing to make the case nationally for the investment our ageing estate needs. The additional £8 million secured for fire safety improvements, alongside the £1.8m secured in September, is important, but it does not remove the need to replace the Tower Block. Our longer-term plan remains to replace the inpatient accommodation currently provided there through the New Hospital Programme.

Torbay Adult Social Care transition programme

57. We continue to work with Torbay Council and the Integrated Care Board to return Adult Social Care services and associated resources on 01 April 2027.

58. Progress is being made, but there are still some issues outstanding to be resolved. These include staff transfer arrangements, service models, case reviews, funding responsibility and cost allocations alongside the development of the retained Health Model

59. The immediate priority remains a safe transfer of care from 01 April 2027, with clarity about the future service offer, statutory responsibilities and the financial consequences for each organisation.

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

60. Work continues to progress the proposed relocation of Cellular Pathology services to Gadeon House, alongside development of the associated business case and supporting documentation.

61. 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.

62. 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.

Pathology accreditation

63. Our Pathology services have completed their latest assessment by the United Kingdom Accreditation Service (UKAS), providing independent assurance of the quality, safety and competence of our laboratory services.

64. Assessors recognised the consistently high quality of our Microbiology and Biochemistry services and the significant improvement made within Cellular Pathology. Cellular Pathology is now reporting 94% of cases within 10 days, above the national standard of 90%.

65. The assessment also highlighted workforce challenges within Haematology and Blood Transfusion, affecting both clinical and biomedical scientist roles, while recognising that the quality of clinical service delivery remains strong.

66. I would like to thank colleagues across Pathology for their work to maintain quality and improve services for patients alongside the pressures and changes they are managing.

Bringing x-rays closer to home

67. We have launched a new mobile x-ray service across Torbay and South Devon, enabling diagnostic imaging to be provided in people's usual place of residence. The service is particularly intended to support older people living with frailty and others who may find it difficult to travel for an x-ray.

68. Using portable equipment, x-rays can be carried out at home, with the images securely reviewed by clinical teams. This will make diagnostic imaging more accessible for these patients and help to reduce unnecessary journeys to hospital.

Research, innovation and access to new treatments

69. We continue to build our research capability and give local people opportunities to benefit from new and emerging treatments.

70. We have secured £88,000 from the National Institute for Health and Care Research (NIHR) for a new negative pressure isolator within pharmacy aseptic services. The equipment will increase our capacity to prepare chemotherapy and other specialist injectable medicines, supporting both routine patient care and clinical trials. The investment also includes two new posts, shared between research and standard care, helping us to open new trials more quickly and increase our capacity for research alongside treatment.

71. Our clinical teams are continuing to give local patients opportunities to take part in national and international research. In haematology, patients are participating in the national Myeloma XV RADAR trial, which is exploring a more personalised

approach to treating myeloma based on patients' diagnosis and their response to initial treatment. One of our patients, John Osborn, recently completed his 100th parkrun exactly a year after his stem cell transplant while continuing his participation in the trial.

72. Our respiratory team is also taking part in the international AIRTIVITY clinical trial, investigating a new targeted anti-inflammatory treatment for people with bronchiectasis. Three patients were recruited at Torbay, matching recruitment at much larger specialist centres. Two members of the respiratory team have also been awarded research associateships by the Regional Research Delivery Network, increasing their capacity to support research at Torbay and South Devon.

73. Alongside this research activity, we are now offering stereotactic ablative radiotherapy (SABR) at Torbay Hospital for men with early-stage localised prostate cancer. SABR delivers targeted radiotherapy in five treatment sessions over two weeks, compared with 20 sessions using standard radiotherapy. Our first local patient is now receiving the treatment, giving eligible patients access to this treatment at Torbay while significantly reducing the number of visits required.

74. Taken together, these developments show how our growing research capability is bringing external investment into our organisation, creating opportunities for local people to participate in clinical research and helping us offer new approaches to treatment closer to home.

Capital investment programme

75. Work continues across a number of our capital programmes at Torbay Hospital.

76. Work is progressing to relocate the Surgical Admissions Unit from Level 7 of the Edwardian Block to Level 5, and we are currently aiming to see the first patient through the new area in the week commencing 7 December. The service will be renamed the Planned Surgery Unit, helping to distinguish it from the Surgical Receiving Unit, which is also based on Level 5.

77. We have now approved the business case for the replacement of our cardiac catheterisation labs, one of our two key capital programmes for this year and next, and it has been submitted to the Devon investment panel as the next stage of the process. Supplier visits are taking place during November to support selection of the specialist equipment, with a preferred supplier expected to be identified during December. The next stage of design work is also under way. We are currently working towards construction starting in April 2027, with the full works expected to be completed by the end of 2027. A temporary cardiac cath lab will enable cardiology services to continue while the replacement works are carried out, with the location and associated arrangements still being worked through.

78. Work is also continuing on the OMFS expansion on level 2 at Torbay Hospital and the new electrical substation, alongside the capital works needed to support the temporary service changes required to reduce occupancy of the Tower Block.

79. On a smaller scale, our new infant feeding room on Level 4 at Torbay Hospital is due to open shortly, providing a dedicated space for people to feed or express milk while at the hospital.

Same Day Emergency Care service

80. Our Same Day Emergency Care (SDEC) service expanded into the Coral Suite on 15 October, significantly increasing capacity and enabling teams to care for up to twice as many patients as before. The service now operates from 8am to 8pm, Monday to Friday, providing rapid assessment, diagnosis and treatment for people who need urgent medical care but do not require an overnight hospital stay.

81. The expansion is helping more people receive the care they need and return home the same day, while helping to keep inpatient beds available for people who need them. It also brings teams together as one Acute Medical Unit as part of our wider preparations for winter.

Appointment priority service at Newton Abbot Urgent Treatment Centre

82. A new appointment priority service was introduced at Newton Abbot Urgent Treatment Centre on 28 September in response to growing demand for urgent care. People with urgent but non-life-threatening conditions are now being asked to book a same-day appointment directly with the centre, giving greater certainty about when they will be seen and helping the service manage demand more effectively at busy times.

83. People can still attend without an appointment, with emergency cases prioritised, although they may wait longer to be seen. The Urgent Treatment Centre continues to operate from 8am to 8pm, seven days a week.

Overnight stays return to our maternity unit

84. From 05 October, families using our maternity services have once again been able to have one person stay overnight on the postnatal ward. Overnight stays were paused during the pandemic, and their reintroduction follows feedback from families and our work with Devon Maternity and Neonatal Voices Partnership.

85. Families told us that having a trusted relative or friend with them overnight provides valuable practical and emotional support in the first hours and days after birth, including with bonding and infant feeding. The change is part of our ongoing work to improve families' experience of our maternity services.

Torbay Hospital League of Friends investment in patient monitoring

86. New patient monitoring technology has been introduced across several services at Torbay Hospital following a significant investment from the Torbay Hospital League of Friends.

87. The investment has provided new equipment and central monitoring systems for the Special Care Baby Unit, Paediatric Emergency Department, Louisa Cary Ward and its High Dependency Unit, as well as Midgley Ward. The technology enables clinical teams to view observations centrally as well as at the bedside,

helping them maintain oversight of patients and identify changes in their condition sooner.

88. For babies and children in particular, central monitoring can also reduce the need for colleagues to enter rooms solely to check equipment, helping to minimise unnecessary disruption while maintaining close clinical observation.

89. I would like to thank the League of Friends for their continued generosity and for supporting an investment that will make a practical difference to patients, families and colleagues.

Our people

Celebrating our Specialty and Specialist doctors

90. We held our annual SAS awards in SAS week in October to recognise and celebrate the achievements of our Specialty and Specialist (SAS) doctors who make an exceptional contribution to patient care, colleagues and services.

91. Dr Gurcharan Dua received the Leadership Award and Dr Ben Bartlett was presented with the Innovation Award. The awards were presented by Dr Kate Lissett, Chief Medical Officer, and the winners will be invited to our annual Our People Awards celebration event next May.

Anaesthetic services achieve national reaccreditation

92. Our anaesthetic team has achieved national accreditation for the third time, making Torbay Hospital one of only eight hospitals in the UK to have achieved this distinction three times.

93. The Royal College of Anaesthetists' Anaesthesia Clinical Services Accreditation scheme assesses services against national standards for patient experience, patient safety and clinical leadership. Following an independent peer review, Torbay was praised for its strong culture of teamwork, communication and patient-centred care.

94. Reviewers highlighted a number of examples of good practice, including the team's 'Home Alone' service, follow-up telephone calls to patients after surgery and the support provided for people with additional needs. One of the lay reviewers commented that they would feel "very safe and well looked after" as a patient at Torbay Hospital.

95. This is an excellent achievement and a reflection of the commitment of our anaesthetic team and colleagues who work alongside them to provide safe, compassionate care for our patients.

Public Health Nursing retains UNICEF Baby Friendly Gold

96. Our 0–19 Public Health Nursing service in Torbay has retained its UNICEF UK Baby Friendly Gold Award, following revalidation in September. The formal assessment highly commended the quality of evidence and the way Baby Friendly standards have been embedded and developed across the service, with the assessor describing it as "absolutely a Gold service".

97. There has also been an improvement in outcomes, with exclusive breastfeeding at six to eight weeks increasing from 35.5% when the service first achieved Gold to 40.9% at revalidation.

98. The assessment highlighted strong leadership and partnership working, including with maternity, perinatal mental health and Action for Children, as well as additional specialist capacity within the Infant Feeding Team. Staff feedback was also very positive: 97% said there was a culture of kindness towards women and families nearly all of the time.

99. The team will now build on the assessment findings, including further work on audit and data and involving staff and families earlier in service development.

Nursing Times Workforce Awards

100. We have been shortlisted in five categories in this year's Nursing Times Workforce Awards, recognising colleagues and programmes supporting workforce development, education and professional practice across Torbay and South Devon.

101. Our finalists are:

- Best Recruitment Experience: Grow Our Own: Healthcare Support Worker to Registered Nurse Pathway
- Internationally Educated Nurse of the Year: Abdul-Manan Alhassan and Gabriel Moroti
- Manager of the Year (Non-Clinical): Rachel Nolan
- Practice Educator of the Year**:** Anitha Rego and Danielle Swift
- Preceptorship Programme of the Year: The 5 Thrive Framework

102. It is particularly pleasing to see recognition spanning individual colleagues as well as programmes supporting people at different stages of their careers. The winners will be announced at the awards ceremony in London on 24 November.

Recognition for student placement experience

103. We have received a Certificate of Recognition from the University of Plymouth for the placement experiences we provide to student nurses and midwives. The recognition is particularly welcome as nominations were made by students studying adult nursing, child health nursing and midwifery.

104. Students highlighted the warm and supportive environments they experienced across our hospital, community and maternity services, as well as the commitment of colleagues to teaching and providing opportunities to learn and develop their clinical skills. Many said their placements had a lasting impact on their confidence, professional development and future career aspirations.

105. This is a welcome recognition of colleagues across Torbay and South Devon who support and inspire our future nurses and midwives.

Supporting families affected by baby loss

106. Around 45 families across Torbay and South Devon experience the loss of a baby before, during or shortly after birth each year. Our specialist bereavement

midwives, Fay Martin and Anna Stewart, support families through their hospital stay and beyond, helping them navigate difficult decisions, create memories of their baby and access ongoing support.

107. The quality of this care received national recognition when Fay was shortlisted for the Elaine Thorp Award for Bereavement Care at the Sands Baby Loss Awards. Fay was nominated by a bereaved mother in recognition of the compassion, kindness and support she received following the loss of her twins.

108. During Baby Loss Awareness Week in October, we also highlighted the wider support available to families, including our work with Luna's Fund, which provides support during pregnancy after loss, wellbeing breaks and opportunities for bereaved families to connect with others who have had similar experiences.

109. Our annual remembrance weekend in December will provide another opportunity for families who have experienced the loss of a baby or young child to come together, remember and receive support.

Rainbow Nursery Ofsted Inspection

110. Rainbow Nursery, which we run, underwent an Ofsted inspection in May 2026. The inspection recognised a number of significant strengths within the nursery, including a Strong judgement for both behaviour, attitudes and routines, and inclusion. Inspectors highlighted the caring and inclusive culture of the nursery, the strong relationships staff build with children and families, and the positive support provided for children with additional needs. Parents told inspectors that their children are thriving, while nursery colleagues were recognised for helping children feel safe, valued and confident.

111. The report also noted the nursery's positive approach to safeguarding and recognised the professional and reflective leadership of the service, alongside the support provided for nursery colleague wellbeing. Inspectors found that leaders have a clear understanding of the difference their actions are making for children and families.

112. As part of its commitment to continuous improvement, the nursery will now focus on the areas identified by Ofsted relating to the consistency of teaching practice, particularly in supporting speech, language and learning development for some older children. The nursery leadership team has reviewed the findings and is taking forward actions to address these recommendations.

113. The inspection provides positive independent assurance regarding the quality of care and support provided by our nursery service, which continues to play an important role in supporting colleagues and local families across Torbay and South Devon.

Staff flu vaccination programme

114. Our seasonal staff flu vaccination campaign began on 01 October as part of our preparations for winter. To date, 38.9% of colleagues have received their vaccination, compared with 29.60% across Devon and Cornwall, 31.60% regionally and 26.90% nationally. We are currently the highest-performing

organisation in Devon and Cornwall for frontline healthcare worker flu vaccination uptake.

115. Last year, 2,380 colleagues (57.54% of our workforce) received a flu vaccination, and this year we are aiming to increase uptake by up to five percentage points. Vaccination clinics are available across our acute and community settings, alongside roving vaccinators, as we continue to encourage colleagues to protect themselves, patients and each other and help reduce the impact of seasonal illness on our workforce over the winter.

NHS staff survey

116. The 2026 NHS staff survey is now underway. At week four, 24.61% of colleagues had completed the survey, ahead of the 22.8% response rate at the same point last year, although below the current national response rate of 29%.

117. We continue to encourage colleagues to take part and share their experiences so that we hear from as many people as possible before the survey closes.

Remembrance and our Armed Forces community

118. On 11 November, colleagues, volunteers and members of our Armed Forces community will come together in the Memory Rose Garden at Torbay Hospital for our annual Act of Remembrance. The service will begin at 10.45am and will include the national two-minute silence at 11am.

119. The service is being organised with colleagues from our Armed Forces community and provides an opportunity to remember those who have served and sacrificed, while also recognising the contribution of veterans, reservists, members of military families and others with connections to the Armed Forces who are part of our organisation and local communities.

120. Our commitment extends beyond Remembrance. Earlier this year we were successfully reaccredited as an NHS Veteran Aware organisation, recognising our work to identify and respond to the needs of serving personnel, veterans and their families and to help ensure they are not disadvantaged when accessing healthcare. We also continue to raise awareness among colleagues of the importance of identifying patients who have served so they can access the support and services available to veterans.

National, regional and local issues and topics of interest

Let's Talk Neighbourhood Health

121. NHS Devon's Let's Talk Neighbourhood Health engagement has been seeking views from staff, patients and communities about how health and care services could work better together in the future. The programme forms part of the wider work to develop neighbourhood health across Devon and has included a county-wide survey, engagement events and other opportunities for people to share their experiences and views.

122. We have actively supported the engagement, promoting opportunities to take part through our internal and external communications channels and supporting

the engagement day at Paignton Library on 25 September. We also wanted to make sure that the experience and expertise of our own colleagues informed the conversation. We therefore adapted the ICB's workshop materials into an online survey, enabling colleagues across our organisation to respond to the full question set in their own time. This received 83 responses from colleagues working across acute, community, specialist, corporate and support services. The raw feedback has been shared with NHS Devon to feed directly into its wider engagement work, while we have also analysed the responses to understand what our colleagues are telling us locally.

123. Following discussion with our Medical Staffing Committee, we also developed a shorter survey for senior medical colleagues, focused specifically on the factors driving demand for specialist services, what currently helps people avoid needing specialist care, what is missing and what could be done differently. This received 18 responses. The report is clear that this is not a representative sample of our medical workforce, but it provides useful insight into the pressures colleagues are seeing and potential opportunities for change.

124. The two resulting reports are included as appendices to my report. Although they involved different groups and asked different questions, there is a striking degree of consistency in what colleagues told us.

125. Neighbourhood health is not primarily described as moving services out of hospital. Instead, colleagues describe a system in which people can get the right support earlier, services communicate and work together, people do not have to repeatedly tell their story, specialist expertise is available when it can make a difference, and health, social care and community support are better connected around the individual.

126. There is strong support for prevention, earlier intervention and care closer to home where this is appropriate. However, both pieces of work also make an important challenge to us and our system partners: these ambitions need to be matched by sufficient workforce, service capacity and infrastructure. Our medical colleagues also caution against assuming that all hospital demand can be prevented or diverted; growing and ageing populations, increasing complexity and genuine clinical need will continue to require acute and specialist capacity.

127. The reports also reinforce the importance of building on what already works. Colleagues identify existing community assets, including voluntary organisations, charities, Family Hubs, carers and community networks, and describe opportunities to strengthen existing integrated and community approaches rather than automatically creating new structures.

128. Taken together, the message is not that colleagues question the direction of neighbourhood health. Their challenge is whether we can create the conditions that will allow it to succeed. The detailed findings will provide useful evidence as we continue our work with NHS Devon and partners on the development of neighbourhood health, while also identifying areas that we can influence directly as a Trust.

Torbay and South Devon NHS Foundation Trust

Our Torbay and South Devon NHS Charity

129. I was delighted to see the completion of Bay of Wonders, a new mural in the children's eye clinic at Torbay Hospital. Created by South West artist Bex Glover in collaboration with colleagues from the eye clinic, it brings together wildlife and plants from across Torbay and South Devon with prehistoric creatures inspired in part by the English Riviera UNESCO Global Geopark. The project has been funded through legacies left to our Charity to support ophthalmology services.

130. Bay of Wonders is the latest project in our established arts programme, supported by our Charity through donations and legacies. We know that the way a healthcare environment looks and feels matters to the people who spend time in it. Through colour, artwork and thoughtful design, our programme is helping us create clinical environments that feel calmer, more welcoming and more supportive of care.

131. Working with our artist in residence, Helen Snell, local and South West artists and creative partners including MAKE Southwest, we have been bringing art into our hospital and community settings for a number of years. This includes our HeArTs gallery at Torbay Hospital as well as commissioned work within clinical areas. The programme gives us an opportunity both to improve the experience of our spaces and to showcase the creativity and character of the communities we serve.

132. Over the coming months, people will see further artwork funded through legacies and donations in parts of our Emergency Department, the new infant feeding room, Heart and Lung waiting area, Endoscopy and discharge lounge at Torbay Hospital, as well as the waiting area for our community dental service at Castle Circus.

133. Our Charity is also becoming increasingly visible across the organisation and in our communities. In September, 25 people took part in the Torbay Half Marathon and 10K for our Charity**,** helping to raise money and awareness through Team Torbay.

134. Our Charity-branded reusable coffee cups and water bottles have now been on sale in Bayview for several weeks. From next year, reusable coffee cups will also be given to people joining our organisation as part of corporate induction. Water bottles are being used to recognise our own award winners and to thank people who take part in fundraising events such as the Torbay Half Marathon and 10K.

135. I would like to thank everyone who supports our Charity, whether by donating, fundraising or leaving a gift in their will. The difference that generosity makes can be seen in projects such as Bay of Wonders and in the many other improvements it enables for patients, families and colleagues across Torbay and South Devon.

Health Bill and local accountability

136. I welcome the Government's announcement that it will no longer proceed with proposals to abolish Healthwatch England and local Healthwatch organisations.

Instead, the Healthwatch model will be retained and strengthened, maintaining an independent route for patients and communities to share their experiences of health and social care and influence improvement.

137. The decision follows considerable concern about the proposals during the Health Bill's passage through Parliament. At the Bill's Second Reading in the House of Lords on 13 October, Peers from across the House emphasised the importance of independent patient voice and local accountability. I welcome the Government listening to those concerns and recognising the importance of retaining an independent voice for patients and communities.

138. There was also significant discussion about the Bill's proposed removal of the statutory Foundation Trust governance model. Peers highlighted the role Councils of Governors play in connecting NHS organisations with their communities, providing local insight and holding boards and non-executive directors to account. We will continue to follow the Bill closely as it progresses through Parliament.

Thirlwall Inquiry

139. Following publication of the Thirlwall Inquiry findings, NHS England Specialised Commissioning has set out five immediate actions for neonatal services. These cover Board consideration of the inquiry findings, Sudden Unexpected Death in Infancy and Childhood (SUDIC) processes, bereavement care, insulin security and safeguarding.

140. The regional Neonatal Critical Care Operational Delivery Network will issue a self-assessment against these actions, which must be returned by 02 December 2026.

141. At the time of writing, we have not yet received the self-assessment.

142. The Thirlwall Inquiry recommendations have significant implications for maternity and neonatal services, but also extend across wider organisational responsibilities including culture, speaking up, leadership, escalation of concerns, multidisciplinary working, patient safety intelligence, governance, Board oversight and organisational learning.

143. One of the actions specifically requires Trust and ICB Boards to review the Thirlwall report and consider its findings, and we will ensure this is taken through the appropriate Board route as part of our response.

Devon SEND inspection

144. The SEND inspection of Devon County Council and its partners has now concluded. Children and Family Health Devon (CFHD), which transferred to Devon Partnership NHS Trust in April, was involved in the inspection as a provider of services for children and young people with special educational needs and disabilities.

145. CFHD colleagues supported the inspection through meetings with inspectors, case reviews and sampling. Initial feedback to the team included positive

comments about practitioners and managers and the way they spoke about their work with children, young people and families. The formal inspection report will be published in due course and will set out the findings and any areas requiring further improvement.

Temporary suspension of birth services at North Devon District Hospital

146. Birth services at North Devon District Hospital remain temporarily suspended following Royal Devon University Healthcare NHS Foundation Trust's latest maternity readiness assessment on 26 October. Royal Devon continues to work towards reopening the service, but a number of its Board-approved staffing and competency criteria have not yet been met. Its next readiness assessment is due on 09 November.

Livewell Southwest leadership changes

147. Sarah Brampton, currently Deputy Chief Executive and Chief Finance Officer at University Hospitals Plymouth NHS Trust, has been announced as the intended new Chief Executive of Livewell Southwest. She brings more than 30 years' NHS experience across acute, mental health and commissioning services.

148. Sarah will succeed Michelle Thomas, who has retired after many years of dedicated service to Livewell Southwest and the wider health and care system. I would like to thank Michelle for her leadership and wish her well for her retirement.

149. Geoff Baines, Deputy Chief Executive and Director of Transformation, is serving as interim Chief Executive from 19 October while Sarah's start date is confirmed.

South Devon College leadership changes

150. Laurence Frewin has announced that he will retire as Principal and Chief Executive of South Devon College at the end of the 2026/27 academic year, following seven years in the role.

151. He will remain in post throughout this academic year and will work with the College's Board to support the transition to his successor.

152. We value immensely our partnership with South Devon College and Laurence has been a fantastic colleague who has championed Torbay and South Debon and worked incredibly hard to provide education and employment opportunities for the communities we serve. We will miss Laurence greatly when he retires and wish him well for the future.

Local media and social media update

153. 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.

154. 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.

155. Since the September Board report, media activity has included coverage of several significant developments across our organisation, including the Tower Block.

- A new Bay of Wonders for children visiting Torbay Hospital's eye clinic
- Further £8m secured for Tower Block fire safety work at Torbay Hospital
- National funding secured at Torbay to support clinical trials
- Torbay anaesthetic team recognised among UK's best for third time
- Hope for Torbay and South Devon patients with a long-term lung condition
- Tower Block, Torbay Hospital – 15 October
- Tower Block, Torbay Hospital – 14 October
- SAS doctors recognised for leadership and innovation at annual awards
- Specialist support helping families through heartbreak and hope
- League of Friends funding helps enhance care for babies, children and young people at Torbay Hospital
- Bereavement midwife recognised at national baby loss awards
- Dying to get a tan? Skin expert shares the signs of skin cancer at free event
- Don't stop me now: John celebrates his 100th park run after blood cancer diagnosis
- First prostate cancer patient in Torbay receives pioneering therapy
- Have a question for our Board?
- Appointment priority service launches at Newton Abbot Urgent Treatment Centre
- Further government funding announced for Torbay Hospital
- Free community health event in Paignton
- Migraine awareness event highlights support available across Torbay and South Devon
- Experienced healthcare and education leader joins our Board of Directors
- Torbay and South Devon NHS shortlisted in five categories at national workforce awards
- Have your say on the future of neighbourhood health and care in Torbay and South Devon
- We are recognised for outstanding student placement experiences
- Our Board meeting in public – Thursday 03 September

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

Torbay and South Devon
NHS Foundation Trust

Let's talk neighbourhood health services colleague insight report

Executive Summary

As part of the wider Devon Let's Talk Neighbourhood Health programme, colleagues across Torbay and South Devon were invited to share their views on the future of neighbourhood health services through an online survey based on the questions contained within the Devon NHS staff workshop-in-a-box toolkit. A total of 83 responses were received from colleagues working across acute services, community services, social care interfaces, specialist clinical services, corporate functions and support services.

The survey was developed because the workshop toolkit contained a large number of questions covering a broad range of themes. While these questions lend themselves well to discussion, it would have been difficult to explore them all meaningfully within a typical 60-90 minute workshop. Converting the question set into a survey enabled colleagues to respond to the full range of topics in their own time, generating detailed qualitative insight both for local learning and for the wider Devon neighbourhood health work.

The findings show a number of recurring themes. Colleagues are broadly supportive of the ambition behind neighbourhood health services. However, their responses also challenge some of the assumptions that can accompany the concept.

Colleagues do not describe neighbourhood health primarily as a programme to move services out of hospital.

Instead, they describe:

- easier access to support.
- better communication between services.
- people only having to tell their story once.
- earlier intervention before needs escalate.
- greater use of community assets and voluntary organisations.
- stronger partnerships between health and social care.
- services organised around people rather than organisations.
- human relationships sitting alongside digital innovation rather than being replaced by it.

Responses focus less on the overall direction of neighbourhood health and more on the conditions required to make it work.

Repeatedly, colleagues return to the same question: how will neighbourhood health improve outcomes if primary care, social care, community services and the workforce are already under significant pressure?

The strongest message is not resistance to neighbourhood health. It is a request for realism about what is required to deliver it.

Methodology

The survey ran between 14 September and 30 September 2026.

The questions were adapted directly from the Let's Talk Neighbourhood Health workshop-in-a-box materials and covered:

- health and wellbeing challenges
- community strengths and assets
- barriers to access
- prevention and early intervention
- future priorities
- digital innovation
- partnership working
- community involvement
- future models of neighbourhood care.

Responses were received from colleagues working in:

- Torbay Hospital and community hospitals
- community health services
- adult social care
- specialist services
- corporate services
- operational management
- administrative and support functions.

This report should be read as a qualitative insight report rather than a statistically representative workforce survey.

Its value lies not in percentages but in the consistency, depth and recurring patterns found across responses.

The raw feedback received through the survey has been shared with NHS Devon so that colleagues' responses can contribute directly to the wider Let's Talk Neighbourhood Health engagement. This report provides our local analysis of that feedback and the themes emerging from it.

What colleagues think neighbourhood health means

The responses show that colleagues' understanding of neighbourhood health extends well beyond a simple "care closer to home" narrative.

While local access is important, responses focus on something broader.

Colleagues describe a system where:

- people know where to go for help
- care is joined up
- information follows the person
- services work together
- support is available earlier
- communities help shape solutions
- people remain independent for longer
- patients and carers do not need to navigate organisational boundaries themselves.

Moving services out of hospital does not dominate the responses. Instead, colleagues talk about:

- coordination
- relationships
- trust
- communication
- accessibility
- continuity

In other words, colleagues primarily describe neighbourhood health as a different way of organising care rather than simply a different place in which care happens.

This distinction matters because it suggests colleagues are already thinking beyond organisational structures and buildings.

The Dominant Themes

1. Access remains a significant system challenge

Access is one of the strongest and most consistent themes across the responses.

Colleagues repeatedly reference:

- GP appointments.
- NHS dentistry.
- Mental health services.
- Community rehabilitation.
- Physiotherapy.
- Community nursing.
- Social care.
- Diagnostics and specialist advice.

Importantly, colleagues rarely describe these as isolated problems.

Instead they connect them to wider pressures across the system.

The picture they paint is consistent:

Difficulty accessing support early leads to:

- deteriorating health
- hospital attendance
- emergency care demand
- delayed discharge
- avoidable admissions
- increasing workforce pressure

A common narrative emerges: when people cannot access help at the front of the system, they eventually enter at the point of crisis.

Across different settings, colleagues describe the consequences of people waiting too long for support, including increasing pressure on emergency care, delayed intervention and people reaching crisis before they receive the help they need.

The survey results therefore present access not as a service-specific issue, but as a whole-system issue.

2. Colleagues are interested in relationships, not structures
One of the most striking findings is how rarely colleagues discuss organisational structures.

Instead they talk about practical relationships.

Repeated themes include:
- being able to contact colleagues directly
- MDTs
- co-location
- joint visits
- shared information
- understanding what services exist
- knowing who is responsible
- reducing duplication
-

The phrase "tell your story once" appears repeatedly in different forms throughout the survey.

This suggests that colleagues understand integration in practical rather than organisational terms.

For them, integration means:
- one conversation
- one plan
- coordinated services
- easier navigation

rather than governance arrangements or formal structures.

This is a notable finding because many policy discussions focus heavily on organisational models.

Colleagues are focused on operational reality.

3. Prevention has strong support but means different things to different people
There is widespread support for prevention and early intervention.

However, colleagues often mean different things when they talk about prevention.

For some respondents prevention means:
- public health
- exercise
- nutrition
- smoking cessation
- health checks
- education
- self-management

- neighbourhood support networks

For others it means:
- easier access to healthcare
- earlier assessments
- quicker diagnostics
- rehabilitation
- proactive monitoring of long-term conditions

These are different approaches but they point towards the same conclusion.

Colleagues consistently believe that services intervene too late.

Numerous respondents describe a system that spends too much time responding to deterioration rather than preventing it.

4. Community assets feature very strongly
The survey contains frequent reference to existing community assets.

Respondents repeatedly mention:
- Family Hubs
- voluntary organisations
- charities
- churches
- libraries
- sports clubs
- support groups
- carers
- community networks

Many responses suggest colleagues think about health as something broader than healthcare. The underlying message is that neighbourhood health should connect more effectively with the strengths already present within communities. This is about building on existing assets rather than creating entirely new services.

5. Digital is widely supported, but digital-only is not
This is more nuanced than might appear at first glance.

Colleagues generally support:
- remote monitoring
- online booking
- shared digital records
- MyCare
- video consultations
- improved digital communication

There is little evidence of resistance to digital innovation itself.

However, a recurring point is that digital should create additional routes into care, rather than becoming the only route.

Groups repeatedly identified as potentially disadvantaged include:

- older people
- people with learning disabilities
- people with cognitive impairment
- those with communication needs
- people without equipment or connectivity
- those who require reassurance and support through discussion.

The recurring view is: digital improves access when it increases choice. It creates barriers when it removes alternatives.

The tensions running through the survey
Alongside these themes, the responses highlight a number of important tensions that will need to be considered as neighbourhood health develops.

Tension 1: Prevention versus capacity
Many respondents argue strongly for prevention.

At the same time many describe services that already lack sufficient staff, appointments and capacity.

This creates an important question.

How can organisations invest in prevention while simultaneously responding to significant operational demand?

Colleagues recognise this challenge.

The survey contains support for prevention, but also repeated warnings that prevention cannot succeed without investment.

Tension 2: Community care versus community capacity
There is strong support for more care being delivered closer to home.

But there is equally strong concern about:

- social care capacity
- community workforce shortages
- therapy waiting lists
- access to carers
- community nursing workload

The vision is widely supported.

The practical challenge is whether sufficient community capacity exists to deliver it.

Tension 3: Personal responsibility versus structural barriers
Some respondents emphasise:

- self-care
- personal responsibility

- health literacy
- making healthier choices

Others focus more heavily on:
- poverty
- transport
- inequalities
- access barriers
- workforce shortages

In practice, these are not opposing viewpoints.

Taken together, the responses recognise that both individual and system factors contribute to health outcomes.

However, they offer different explanations for why people struggle to stay healthy.

This is an important distinction when considering future neighbourhood health models.

Tension 4: New models versus existing strengths
Some responses describe elements of neighbourhood health as already happening in practice.

Integrated teams, home visiting, Family Hubs and MDT working are all identified as existing strengths.

This creates a subtle challenge.

Colleagues are often less interested in creating entirely new models than in strengthening what already exists.

A recurring message is: understand what is already working before building something new.

What we should keep in mind
There is a temptation to interpret these findings as a list of recommendations.

They are more valuable than that.

Taken together, the responses provide an organisational view of how colleagues think a neighbourhood health system actually works.

The responses do not suggest significant opposition to the principles of neighbourhood health.

Nor do they reveal a workforce preoccupied with organisational structures.

Instead, colleagues consistently describe a system built around:
- better access

- stronger relationships
- earlier intervention
- community assets
- integrated teams
- shared information
- human connection
- sufficient workforce capacity

The strongest warning running through the responses is not about the direction of travel.

It is about implementation.

Colleagues largely support the ambition.

Their question is whether the workforce, community services, social care capacity and primary care infrastructure required to deliver that ambition will be in place.

Ultimately, the responses show considerable alignment with the principles of neighbourhood health. The bigger challenge identified by colleagues is not defining the vision, but creating the conditions that allow that vision to become reality.

Torbay and South Devon
NHS Foundation Trust

Shaping future neighbourhood health services

Summary of feedback from senior medical colleagues

How this insight was gathered

Following feedback from the Medical Staffing Committee, the wider Let's Talk Neighbourhood Health question set was simplified to five questions focused on specialty demand. This made the exercise more proportionate for senior medical colleagues and concentrated the responses on the factors driving demand, what currently helps patients avoid specialist care, what is missing, what could reduce future demand and what the Trust itself could influence.

The five questions were:
• What are the main factors driving demand within your specialty?
• What support currently helps patients avoid needing your service?
• What support is missing, or insufficient, and results in people needing your service?
• What could be done differently to reduce future demand and improve outcomes for people who might otherwise require specialist care?
• From your perspective, is there anything the Trust could do to help reduce referrals to your specialty?

The feedback describes rising demand as the result of several pressures acting together: changing population need, difficulty accessing timely care outside hospital, gaps between services, increasing clinical complexity, workforce constraints and delays within the hospital itself.

The survey received 18 responses. While this is not a representative sample of the several hundred consultants and SAS doctors working across our organisation, the feedback offers valuable insight into the pressures colleagues are seeing within their services and the changes they believe could improve outcomes and manage future demand. Some specialties are represented more strongly than others and the depth of individual responses varies. The themes should therefore be treated as a starting point for discussion, further testing and service-level analysis, rather than a definitive view of the medical workforce.

Demand reflects changing and increasingly complex need

Medical colleagues do not suggest that demand can be managed simply by reducing referrals. Much of the growth reflects genuine need. Our population is ageing, more people are living with several conditions, cancer diagnosis and treatment are increasing, and advances in care mean patients require longer-term specialist follow-up.

Different specialties see this in different ways. Cardiology, urology and acute medicine describe the effect of an ageing population and increasing comorbidity. Haematology is caring for people who are living longer and receiving multiple lines of ongoing treatment, requiring regular specialist review. Oncology reports more cancer diagnoses, an increasing range of treatments and growing expectations of care. Orthopaedic trauma also identifies old age and growth in the local population,

alongside rising diabetic foot infections with potentially life- or limb-threatening consequences and more spinal presentations to the on-call and emergency orthopaedic team.

Children's services are seeing growth in neurodevelopmental conditions, mental health needs, obesity, long-term conditions and medical complexity. These pressures are compounded by poverty, safeguarding concerns and reduced family support. Many of these needs cross health, education and social care, but families must still navigate separate services and thresholds.

The feedback therefore cautions against treating all growth in referrals or hospital use as avoidable. Some activity could be managed differently, but services must also plan for a real increase in clinical need.

Timely access to primary and community care matters
A strong message is that timely access to trusted primary and community care can prevent people reaching hospital unnecessarily. Where patients can obtain advice, reassurance, monitoring and early treatment, their needs may be managed without an emergency attendance or specialist appointment.

Where that support is difficult to access, specialist and emergency services become the available alternative. The feedback identifies difficulty obtaining GP, practice nurse and out-of-hours appointments; limited capacity for routine wound care and post-operative follow-up; gaps in chronic disease management, including diabetes and osteoporosis; and barriers for visitors who need to register temporarily with a GP. Patients may also perceive that they cannot access primary care and seek help elsewhere.

The same issue affects clinicians. When it takes too long to contact a specialty or there is no straightforward route to obtain advice, ED may become the route into hospital care. Referral decisions are therefore shaped not only by clinical need, but by which services can be reached at the time the patient needs help.

Some comments are critical of primary care capacity, knowledge or referral practice. However, the feedback also recognises that primary care colleagues are working under considerable pressure and may lack easy access to specialist advice, diagnostics and alternative pathways. One respondent explicitly describes this as a communication problem between primary and specialist care, rather than a criticism of primary care.

The findings should therefore not be reduced to a concern about inappropriate referrals. They point to an interface between services that is often too difficult to navigate for patients and clinicians.

Specialist knowledge needs to be available earlier
There is considerable support for making specialist expertise available earlier, without requiring every patient to enter a specialist service fully.

Suggestions include:
- consultant advice and guidance

- reliable contact routes for GPs and community clinicians
- regular multidisciplinary discussions
- specialty triage before an appointment is booked
- rapid-access or hot clinics
- same-day and next-day assessment
- specialist-led virtual wards
- supported self-management with straightforward access back into services
- education and skills development for primary care, ED and community teams.

The aim would be to reach a clinical decision earlier, manage more patients safely in the most appropriate setting and preserve specialist appointments and hospital admission for those who need them.

This does not mean transferring specialist workloads into the community without additional support. Advice, triage, education and multidisciplinary working all require clinical time. They will need to be reflected in workforce planning, job plans and service capacity if they are to change demand rather than add another responsibility to stretched teams.

Clear pathways must be matched by accessible clinical advice
Several specialties describe referrals reaching them without the recommended assessment, investigations or initial management. Better referral guidance and greater consistency could prevent unnecessary appointments and help patients reach the right service more quickly.

However, guidance alone is unlikely to change demand. Primary and community clinicians need quick access to specialist advice when a patient does not fit neatly into a pathway or when there is uncertainty about risk. Pathways also need the necessary diagnostics, prescribing arrangements and community services behind them.

The feedback provides several practical examples:

- Urology identifies opportunities for bladder scanning in primary care, use of frequency-volume charts, ultrasound before referral, nurse-led benign pathways and changes to prescribing arrangements.
- Haematology highlights the use of existing guidance for minor blood-count abnormalities, better access to appropriate tests and phlebotomy, and supported self-management after treatment.
- Cardiology identifies clearer criteria for new and follow-up appointments, stronger management of hypertension and lipids, and specialist-guided admission avoidance.
- Oncology proposes an SDEC service for urgent cancer presentations.
- Imaging highlights the value of earlier senior decision-making and better access to alternatives such as endoscopy
- Orthopaedic trauma highlights stronger diabetes and osteoporosis management and proposes a fracture liaison service to support secondary prevention in vulnerable patients.

Some current pathways appear to create avoidable activity. The absence of diagnostic equipment or specialist nursing support can result in more than one hospital visit. Unclear post-operative instructions can leave patients unable to

arrange routine follow-up. Difficulty contacting a specialty can direct patients through ED. These are not simply problems with individual referral decisions; they reflect how services and access routes are designed.

Children and young people need a distinct approach
The responses relating to children and young people describe a particularly clear set of issues. Gaps are identified in primary paediatric knowledge and confidence, early help, health visiting, school nursing, mental health support, neurodevelopmental pathways, therapy, family support and healthy-weight services.

Families may reach specialist paediatrics because they have been unable to obtain timely advice or reassurance elsewhere, because community services have long waits or because their child does not meet the threshold for specialist mental health support. Concerns prompted by information on social media may also increase the perceived need to see a specialist when trusted reassurance is not readily available in the community.

The feedback points towards an integrated neighbourhood child-health model involving primary care, paediatrics, mental health services, community teams, education, local authorities and family support. Consultant advice, regular multidisciplinary discussions and workforce development could contribute to this, but the model would also need the early-help and community services that families require before their needs escalate.

There is also a warning about unintended consequences. Directing children with primary-care-type problems from ED into acute paediatrics may resolve an immediate operational issue, but could reinforce the belief that hospital specialist care was necessary. Redesign must therefore consider the future behaviour it encourages as well as the patient’s immediate destination.

Children and young people should be designed into neighbourhood services from the outset, rather than added later to a model developed primarily around adult demand.

Urgent and emergency care absorbs pressure from across the system
Urgent and emergency care provides the clearest illustration of how the different pressures connect. ED receives patients who have been unable to access another service, have been directed there by NHS 111, need mental health support that is not available in the community or cannot reach the relevant specialty directly.

When ED is crowded, timely and considered decision-making becomes harder. Referral to acute medicine can become the quickest available next step, even where another route might have been more appropriate for the patient.

Suggestions include:
- additional senior clinical review of NHS 111 referrals to ED
- stronger GP provision at Newton Abbot UTC
- a single point of access for ambulance and community referrals
- clear routes to ED, specialist care, SDEC, next-day assessment, frailty services or admission

- faster specialty acceptance and movement of patients out of ED
- earlier identification of people who could be discharged or supported through a virtual ward
- access to rapid specialist follow-up so that non-urgent investigations do not have to be completed during an admission.

However, colleagues also warn against assuming that alternative pathways will remove the need for acute beds. Many patients waiting in ED genuinely need admission. SDEC, virtual wards and hot clinics can strengthen the range of options available, but they cannot substitute for sufficient acute capacity or resolve delays in discharge and care provision.

The feedback is therefore asking for a balanced approach: improve alternatives where they are clinically appropriate, while recognising and planning for the demand that cannot safely be diverted.

Earlier senior decisions could reduce avoidable activity
The feedback on imaging highlights a wider concern about when senior clinical decisions are made. Increasing reliance on imaging is linked to more junior assessments without early senior or subspecialty support, as well as difficulty accessing alternative forms of investigation.

Earlier senior review may help avoid unnecessary investigations, referrals and admissions. It may also give teams greater confidence to discharge a patient with a clear plan for investigation and follow-up, rather than keeping them in hospital until every test has been completed.

This is not solely an imaging issue. The same principle applies at several points in the patient journey:

- when NHS 111 is deciding whether someone needs ED
- when a GP is considering referral
- when a patient first arrives in ED
- when a specialty receives an urgent request
- during the post-take ward round
- when a patient could potentially return home with follow-up or virtual support.

Making senior expertise available at these points may improve decisions and reduce duplication, but it depends on having enough senior clinical capacity to support urgent care without weakening outpatient and elective services.

Prevention must be connected to service delivery
The feedback supports a stronger focus on prevention and early intervention, but colleagues describe specific clinical opportunities rather than a general ambition to keep people well.

These include:

- better hypertension and lipid management
- smoking cessation alongside lung cancer screening
- support for families to develop healthy and active lifestyles
- earlier help with children’s mental health, development and behaviour

- better management of long-term conditions
- support for people whose physical health is affected by trauma and wider social circumstances
- better diabetes management to reduce severe diabetic foot complications
- osteoporosis management and fracture liaison to reduce repeat fractures among vulnerable patients

The orthopaedic trauma response makes an important distinction between preventing a first presentation and preventing a further one. A fracture liaison service would not necessarily reduce first-time fractures, but could reduce re-presentations by identifying and managing osteoporosis and other risks after the initial event.

Lung cancer screening illustrates the relationship between current and future demand. Screening increases the immediate need for diagnostics, clinic capacity and clinical time, but can reduce later presentation with advanced disease. The feedback argues that this longer-term benefit needs to be recognised through sufficient support for the programme and for smoking cessation.

One acute medicine response also describes a group of patients with persistent symptoms associated with trauma, poor health and wider life circumstances who do not fit easily within an individual organ-based service. This raises a broader question about whether neighbourhood teams can offer a more joined-up response to people whose needs span physical, psychological and social care.

Prevention will only affect demand if it is connected to accessible services, clinical pathways and sustained capacity.

Hospital flow is part of the demand challenge
The feedback broadens the discussion beyond referrals and admission avoidance. Delayed discharge, waits for packages of care and possible early readmissions among frail older people are also placing pressure on the hospital.

One response raises concern that patients who are medically optimised are waiting several days for support that was previously available more quickly. It also questions whether failed discharge and early return to hospital are adding avoidable pressure at the beginning of the admissions pathway. The respondent calls for data to establish whether this perceived change is happening and what role discharge processes may be playing.

Reducing referrals will have limited effect if patients who need admission cannot move through and out of hospital. Equally, faster discharge will not improve care if people return soon afterwards because the arrangements supporting them were insufficient.

Neighbourhood health services, acute flow and discharge should therefore be considered as connected parts of the same patient journey.

Workforce and infrastructure will determine what is possible
Workforce pressure is identified directly within urology, haematology, oncology, imaging and acute services. The feedback also identifies constraints in primary care,

mental health, health visiting, school nursing, therapy, community nursing, social care and care provision.

Many of the proposed solutions require additional or differently deployed clinical capacity. Consultants would need time to provide advice, participate in neighbourhood multidisciplinary teams, triage referrals, support virtual care and develop pathways. Services would need staff to run rapid-access clinics, SDEC and nurse-led pathways. Some proposals also require equipment, diagnostic capacity, estate and administrative support.

These changes may release capacity later, but they are not cost-free at the point of introduction. Moving specialist expertise earlier in the pathway without protecting the necessary time risks adding work rather than changing where demand is managed.

Patterns and tensions across specialties
Taken together, the responses suggest several different types of demand. Some is driven by population growth, ageing, multimorbidity and longer survival with conditions requiring ongoing treatment. Some arises when timely primary, community or mental health support is unavailable. Some is generated by the way pathways are designed, including limited access to advice, delayed senior decisions, missing diagnostics, unclear follow-up and services that do not connect easily. Some activity is also the intended short-term consequence of prevention and case finding, as illustrated by lung cancer screening. These types of demand need different responses and should not be treated as one problem.

The clearest tension is between reducing avoidable activity and planning for genuine need. Better access, prevention, referral guidance and earlier specialist input can change some demand. They cannot remove the need created by an ageing population, increasing complexity, more cancer diagnosis and treatment, or patients who genuinely require admission and specialist care. The task is therefore to identify what can safely be prevented or managed differently without allowing that ambition to obscure the capacity still required.

There is a second tension between earlier specialist input and finite specialist capacity. Advice and guidance, triage, multidisciplinary discussion, hot clinics and virtual models may prevent later escalation, but they draw on the same clinicians responsible for outpatient, elective, inpatient and on-call work. Their value will depend on where specialist time has the greatest effect, what activity changes as a result and whether that time is recognised in job plans and service capacity.

The responses also show that clearer pathways are necessary but not sufficient. Guidance can improve consistency, but many patients do not fit neatly into a single pathway because they have several conditions, uncertain risk or needs spanning physical, psychological and social care. Pathways therefore need accessible clinical advice, the necessary diagnostics and services behind them, and a route for professional judgement when the answer is not straightforward.

Finally, the feedback draws a useful distinction between what we can influence directly and what depends on the wider system. We can improve access to specialist advice, internal referral and follow-up routes, senior decision-making, discharge

information and specialty-specific models. Primary care capacity, NHS 111, community mental health, social care, children's early help, smoking cessation and wider prevention require action with the ICB and partners. Being clear about that distinction will help avoid presenting system constraints as problems that an individual Trust pathway can resolve on its own.

What we could influence
We cannot address all the issues raised through internal service redesign. Primary care capacity, NHS 111, community mental health provision, social care, children's early help, smoking cessation, chronic disease management and wider prevention require work with the ICB and other partners.

There are, however, areas where we could take a lead:

- make specialist advice easier and quicker to access
- identify referral routes that create avoidable delay, duplication or hospital attendance
- agree clear criteria for new and follow-up appointments
- improve communication with primary care and involve referrers in pathway design
- increase senior clinical input at high-impact decision points
- improve discharge information, investigation plans and access to follow-up
- explore nurse-led, one-stop, rapid-access, SDEC and virtual models where there is a clear clinical case
- support education and skills development across hospital, primary and community care
- consider specialty-specific prevention proposals, including fracture liaison and stronger links with diabetes and osteoporosis management
- use data to test assumptions about referrals, rejected referrals, imaging, admission, discharge and readmission
- bring clinical evidence into discussions with the ICB and system partners.

Overall conclusion
The feedback suggests that neighbourhood health services need to do more than move existing activity from hospital into a different setting.

They should make it easier for patients to receive experienced clinical advice earlier, connect generalist and specialist care more effectively and provide credible alternatives to hospital where those alternatives are safe and properly resourced.

They should also recognise the needs of people who do not fit neatly into a single specialty pathway.

We have an important role in making our expertise and pathways easier to access, but many of the underlying pressures require action across primary care, community services, mental health, social care, education and the wider system.

Alongside this, we must be honest about the demand that cannot be prevented.

Neighbourhood working, admission avoidance and prevention can improve care and make better use of resources, but they cannot replace the workforce, hospital beds,

diagnostics, community provision and social care capacity needed by people with genuine and increasingly complex needs.

Questions for further exploration

1. Where could earlier specialist input make the greatest difference to patient care and downstream demand?
2. Which referral and advice routes currently create the most delay, duplication or unnecessary hospital attendance?
3. What clinical capacity would be needed to support advice, triage and neighbourhood working properly?
4. Which of the specialty-specific proposals, including fracture liaison, are ready for more detailed exploration or testing?
5. What should the Trust lead directly, and what needs to be taken forward with primary care, the ICB and other partners?
6. What data is needed to understand changes in referrals, rejected referrals, investigations, admissions, discharge and readmission?
7. How should children and young people be designed into neighbourhood services from the outset?
8. How can we strengthen alternatives to hospital without understating the acute and inpatient capacity that patients still need?

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Presented to:	**Trust Public Board**			
Title of Report	October Board Assurance Framework and Corporate Risk Register			
Date of Meeting	**5 November 2026**	**Author**	Cath Parnell, Associate Director of Corporate Governance and Trust Secretary	
Executive Lead	**JoeTeape - CEO**	**Executive Sign Off**	Yes	
Governance Route	Quality and People Committee 27 October 2026 Finance and Operations Committee 28 October 2026 Audit and Risk Committee 29 October 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. The framework is now becoming established as business as usual (BAU), with routine Executive Team review focused on increasing its maturity through consistent risk ownership, stronger evidence of control effectiveness and clearer assurance on strategic delivery and committee oversight. This paper summarises highlights changes from August to October 2026. The full October BAF and CRR are listed as companion appendices with Appendix One providing the comparison. Reporting will continue to be refined through future governance cycles, taking account of Board feedback and opportunities to improve clarity, escalation and assurance. **<u>October BAF – changes since August 2026</u>** The October 2026 BAF records broadly unchanged principal risk scores, but the August–October period includes material changes in recorded corporate exposure, controls and assurance. Most of the BAF domains remain above target. The Board is advised that unchanged scores do not indicate an acceptable risk position or demonstrate sustained risk reduction. The key points for the Board are: • <u>Persistent strategic exposure</u>: Quality remains at 12 (target 8), Finance at 12 (target 8), Performance and			

	Digital and Data at 16 (targets 12), Leadership and Governance at 8 (target 6), and Organisational Transition at a reported 20 (target 9). People and Culture is at its target of 12, but recruitment, wellbeing and culture controls still require further assurance. • Material partnership and transition changes: Partnership and System now records four CRR risks with an aggregate of 20, compared with no risks recorded in August. Organisational Transition has increased from a CRR aggregate of 12 to 20, with separate risks for the Section 75 transition and adult social care bad debt. Strategy and Transformation has increased from 12 to 16, reflecting clearer recording of delivery and Gadeon House dependencies. • Strengthened controls, with continuing delivery gaps: Post-Epic activity-recovery and community-performance reporting actions are recorded as completed; urgent care and RTT improvement was reported to October FOC, but long waits and cancer recovery remain concerns. Tower fire risk remains 25, with a greater understanding of the requirement for an integrated, funded delivery and assurance plan and quantified operational impacts. Digital resilience and business-intelligence capacity continue to constrain assurance. • Embedding and assurance remain incomplete: Reporting now distinguishes completed Quarter 2 actions from Quarter 3 delivery and embedding milestones. Independent Freedom to Speak Up arrangements were launched in October. Consistent risk ownership, credible evidence of control effectiveness, timely review and action closure remain priorities, supported by planned post-implementation testing, targeted deep dives and quarterly trend reporting. **October CRR – changes since August 2026** Recorded CRR aggregates have reduced since August for: • Finance (25 to 16), • Performance (20 to 12), • Estates (20 to 12), • Health and Safety (20 to 12), • Workforce (20 to 12), Infection Prevention and Control (15 to 9), • Digital, Cyber and Data (20 to 12),

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	• Business Continuity (12 to 9). September included recalculation of aggregates and refinement of risk categorisation therefore these movements are not currently a like-for-like measure of reduced exposure. Significant individual risks persist, including Tower fire safety at 25 and financial sustainability at 25. The Board is asked to note the August–October changes, retain Limited assurance and maintain oversight of outstanding mitigations and reporting reconciliation.

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 Board visibility of August–October changes in principal risks, controls, assurance gaps and required actions, with clearer alignment between the BAF, CRR and committee scrutiny. Material partnership and transition exposures and unresolved reporting inconsistencies remain. Improved reporting does not itself demonstrate sustained risk reduction; continued oversight is 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

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	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	Limited assurance remains appropriate despite improved BAF/CRR alignment, controls and delivery milestones. Most domains remain above target; significant risks persist and partnership and transition exposure has increased. Quality intelligence, digital resilience, workforce sustainability and Tower delivery assurance remain incomplete. Recalculation, reclassification and source inconsistencies limit trend assessment. Evidence of consistent application, timely review and action closure, risk reduction and improved outcomes are still required.			
Appendices	Appendix One – Summary of Material BAF and CRR Changes from August to October 2026 Appendix Two – Board Assurance Framework October 2026 Appendix Three – Corporate Risk Register October 2026			

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Appendix One – Summary of Material BAF and CRR Changes from August to October 2026

Area	October 2026 position	Change from August 2026
Overall strategic risk profile	Most BAF scores remain above target. Significant individual risks persist despite lower recorded aggregates in several CRR categories. Overall assurance remains Limited.	Material changes in partnership, transition and transformation recording; lower aggregates elsewhere partly reflect September recalculation and categorisation changes. Unchanged BAF scores and improved reporting do not demonstrate acceptable exposure or sustained risk reduction.
Quality, Safety, Clinical Outcomes and Patient Experience	BAF 12 (target 8). Clinical Safety CRR 12; IPC 9; Health and Safety 12. Tower fire risk remains 25. Quality intelligence and patient-experience triangulation remain incomplete.	Thirlwall implementation is explicitly recorded. Clinical risk count increased from 150 to 158. IPC aggregate reduced from 15 to 9 and Health and Safety from 20 to 12, subject to recalculation caveats. Staffing mitigation actions moved to business as usual; independent quality-impact assurance was deferred to Q4 owing to capacity constraints.
People and Culture	BAF 12, at target. Workforce CRR aggregate 12 across 57 risks, with five reported at 15 or above. Recruitment, wellbeing, culture insight and integrated workforce data remain assurance gaps.	CRR aggregate reduced from 20 to 12; recorded risks increased from 52 to 57. The People Strategy development action is complete and delivery milestones are clearer. Independent Freedom to Speak Up launched in October; recruitment pipeline, wellbeing and culture-dashboard work continues. Target attainment does not remove specialist staffing or bank/agency dependency risks.
Health Inequalities and Population Health	BAF 12 (target 9). CRR aggregate 9 across three risks, with none at 15 or above; this within appetite. Neighbourhood analytics and measurable outcomes remain developing.	CRR aggregate reduced from 16 to 9 after interventional radiology reclassification. This is not evidence of reduced inequalities. Appointment of the ICB Place Director and neighbourhood recruitment support joint

		planning; a draft prevention outcomes framework is with the ICB.
Finance	BAF 12 (target 8). CRR aggregate 16 across 17 risks; financial sustainability remains 25. Recurrent savings, productivity, constrained capital and shared procurement delivery remain key concerns.	Recorded aggregate reduced from 25 to 16, with recalculation limiting comparability. Devon Procurement Service is now explicitly recorded at 16. Variable-pay controls strengthened; activity-income recovery actions are complete. Adult social care debt analysis is complete but transfer arrangements remain to be agreed. NHS SBS go-live has been reset to 1 April 2027.
Performance and Patient Flow	BAF 16 (target 12). CRR aggregate 12 across 39 risks, with three at 15 or above. RTT data and waiting-list risk remains 20; cancer risk 16; capacity and flow risk 15.	Recorded aggregate reduced from 20 to 12. Post-Epic recovery actions and community-performance reporting are complete, without resolving all data risks. October indicates improved urgent care, the opening of the unscheduled care village and RTT above the local gateway, but persistent long waits and deteriorating cancer performance. Recovery-plan assurance remains distinct from achievement of national standards.
Estates, Infrastructure and Digital Enablement	Estates CRR aggregate 12; overarching estates risk 25 and cancer-building risk 20. Digital BAF 16 (target 12); Digital, Cyber and Data CRR 12; Information Governance 9.	Estates and Digital CRR aggregates reduced from 20 to 12; the £120m-plus backlog and capital constraints remain. Cyber internal-audit follow-up improved to Significant assurance, while the BAF cyber control remains Limited. AI and innovation controls are now explicit; disaster-recovery testing moved to Q4 owing to recruitment constraints. Business-intelligence capacity remains a cross-cutting gap.
Partnership and System	BAF 12 (target 8). CRR aggregate 20 across four risks, with three reported at 15 or above. System	No CRR risks were recorded in August; October now captures material shared-service and system dependencies. This

	working, Devon clinical strategy, pathology partnership and shared EPR governance require Board oversight.	reflects improved identification as well as exposure, not the emergence of new risks during the period. Joint accountability, agreements and escalation are being strengthened.
Leadership and Governance	BAF 8 (target 6). Legal and Regulatory and Communication and Reputation CRR aggregates remain 12. Risk-management control assurance remains Limited.	Tier 2/3 governance redesign is substantially complete. Independent Freedom to Speak Up service launched in October. Sustained control effectiveness remain priorities.
Strategy and Business	BAF 16 (target 12). Strategy and Transformation CRR aggregate 16, with strategy delivery and Gadeon House risks at 20. Tower fire risk remains 25 in Health and Safety; business-continuity aggregate is 9.	Strategy CRR aggregate increased from 12 to 16 with clearer recording of transformation and pathology-delivery dependencies. Benefits-realisation methodology and initial Tower governance actions are recorded complete. Enforcement has accelerated Tower solutions, but a funded integrated plan, external commitments, contingencies and quantified impacts on quality, capacity, workforce, finance and performance remain a clear focus for the Trust. Business-continuity aggregate reduced from 12 to 9 without demonstrating full resilience.
Organisational Transition	BAF reported total 20 (target 9). CRR aggregate 20 across two corporate risks: adult social care bad-debt transfer 20 and Section 75 transition 16. Service continuity and financial, workforce and contractual arrangements remain priorities.	CRR aggregate increased from 12 to 20, separately recognising debt-transfer exposure. deadlines moved to Q3. Joint quality/safety governance has been developed, with further review and reporting planned. Workforce, delegated healthcare tasks and service-user impacts still require assurance.

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Board Assurance Framework

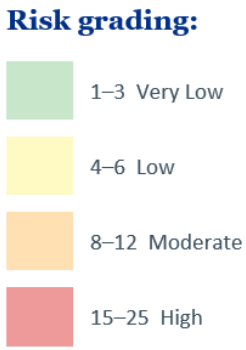
2026/2027

October 2026 v1 Final

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



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

Appetite	NPSA Band	Possible Scores	Tolerance	What this means in practice
Very Low	*1–3*	*1, 2, 3*	**>3**	*The Trust will take all reasonable steps to eliminate or mitigate these risks. Any residual risk above the threshold requires Board visibility.*
Low	*4–6*	*4, 5, 6*	**>6**	*Preference for safe delivery options with low degree of inherent risk. Risks are actively managed and must be escalated where controls are insufficient.*
Moderate	*8–12*	*8, 9, 10, 12*	**>12**	*Some risk is inherent in transforming how we work and collaborate across the system. Acceptable where controls are in place and the risk is actively managed.*
High	*15–25*	*15, 16, 20, 25*	**>20**	*Delivering the five signature moves requires bold decisions. The Trust is willing to accept elevated risk where the benefit to patients and communities is clear.*

Scores 7, 11, 13 and 14 do not exist in a 5×5 NPSA matrix.

Tolerance thresholds are set at the top of each band. Where a risk score exceeds the threshold for its category, escalation is required via the appropriate processes as defined in the Risk Management Policy and Risk Management Operating Manual.

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 / Chief Medical Officer	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	Limited assurance, with improving trajectory. Assurance is provided through IPC governance, HCAI surveillance, outbreak reporting, audit and improvement activity. However, residual risks associated with the ageing estate, isolation capacity and the need to demonstrate sustained improvement mean that Moderate assurance is not yet evidenced. The assurance rating will be formally reviewed next cycle against current HCAI performance, IPC audit compliance, outbreaks and delivery of estate/isolation mitigations	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
C7	Board-approved patient experience strategy and improvement programme, with executive accountability, co-production with patients and carers, routine triangulation of feedback, complaints, PALS, survey, equality and quality data, and ward-to-board oversight of measurable improvement actions.	Patient experience governance, co-production and ward-to-board reporting provide oversight of feedback and improvement actions; reporting included consistent triangulation methodology	Limited
C8	Children and young people's services governance framework, with named executive and clinical accountability, safeguarding oversight, compliance with statutory and regulatory standards,	Assurance is provided through safeguarding and children's services governance reports, statutory safeguarding partnership arrangements, child death review learning, incident and complaint themes, workforce and training compliance, patient and family feedback, CQC insight and action plans arising	Moderate

	child death review processes, mandatory training and routine escalation of quality, safety and experience risks from service to Board.	from national reviews and recommendations. Material risks, gaps and overdue actions are escalated through Quality and People Committee to the Board.	

Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Currently limited robust, sustainable and auditable process in place to identify speciality-level triggers, for example higher than expected complaints, harm etc.	Develop and deliver a trigger alert system to identify unexpected higher than expected changes in mortality, harm, complaints, experience and staffing, with actions tracked through care group governance. Trigger system to be developed in Q3, with first cut of data available in Q4.	Chief Medical Officer	Q3/Q4 26/27
GC	Vacancies and temporary staffing, both medical and clinical, 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. **Completed – moved to BAU management**	Chief People Officer	Q2 26/27 **Completed**
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
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. Planning underway but currently constrained by unplanned staff absence	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. *October 2026 – Further unplanned staff absences has delayed the ability to progress this without detriment to other activities. Work continues but deadline extended further to allow prioritisation of competing requirements to take place.*	Chief Nursing Officer	~~Q1 26/27~~ ~~Q2 26/27~~ Q4 26/27 *Deadline extended due to extended unplanned resourcing constraints*

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: 3 x 4 = 12	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
C7	Compliance with national standards and recommendations	Sexual safety 10 x commitments Mann Review recommendations to address racism	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. Approval through PEGG and recommendation to TEG in September 2026 QPC assurance in September 2026.	Chief People Officer	Q2 26/27 **Completed**
GC	Delivery of People Strategy	Delivery of 2026/27 actions as detailed in the plans on a page. Delivery will be monitored through the People and Education Governance Group.	Chief People Officer	Q4 26/27
GC	Ineffective People and Education Directorate staffing model to deliver strategy.	Restructure consultation and revised structure implemented. Phase 1 completed.	Chief People Officer	Q4 26/27

		Phase 2 underway and due to be implemented from October 2026.		
GC	Persistent vacancies in nursing, medical and allied health professionals workforce groups	Expand recruitment pipeline; grow-your-own; advanced practice expansion. HRBPs to support care groups with plans for hard to recruit to roles/services and fragile services. Learning Academy to prioritise pathways for local recruitment, Advanced Practice and fragile services. Recruitment plan to be presented to QPC in October for assurance.	Chief People Officer	Q3
GC	Wellbeing offer and routes to speak up and access support do not meet workforce needs	Strengthened independent FTSU function commissioned and due to be implemented from October 2026. **Complete** – new model being implemented. Wellbeing business case approval in August 2026: Implement musculoskeletal, mental health and staff health checks; wellbeing website and resources including clearer pathways & signposting. Post in process of being advertised, resource and website being updated. Guidance on standards of behaviour to be developed. Framework socialisation will finish at the end of October and will be launched in November. Occupational health service review and recommendation for future model. Strengthened wellbeing and staff engagement support resource delivered through people directorate org change. Phase 2 will be implemented from October onwards. CARES-Well project to implemented with partners to support evaluation and impact. Have agreed immediate actions for Q3 activity.	Chief People Officer	Q2 26/27 **Complete** Q3 26/27 Q3 26/27 Q3 26/27 Q3 26/27
GC	The Learning Academy model, governance and delivery plan are not yet fully developed, limiting a coordinated approach to workforce skills, career pathways and organisational learning.	Approve the Learning Academy model, governance and delivery plan; Complete workforce learning and skills need analysis. Prioritise career pathways and development offer. Monitor participation, equality of access, skills impact and benefits through PEGG and CIRG.	Chief People Officer	Q3 26/27
GC	Insufficient proactive and timely insight into emerging cultural challenges across services, limiting early intervention and targeted improvement.	Establish CIRG and the culture dashboard. Establish routine culture surveillance by triangulating staff survey, pulse survey, FTSU, employee relations, absence, turnover, incident and network insight; identify hotspots and emerging themes; agree targeted interventions with accountable leads; and monitor impact through PEGG and CIRG.	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. Align to specialty reports, performance, quality and finance.	Chief People Officer	Q3 26/27
GA	Compliance with national recommendations and policy – Sexual Safety and Racism Implementation of NHS Staff Standards and Leadership and Management Framework.	Implementation of the Mann Review recommendations. Implementation of the sexual safety 10 x commitments for Trusts. Implementation of NHS Staff Standards. Implementation of Leadership and Management Framework.	Chief People Officer	Q3/4 26/27

		Policy and processes implemented. Aspects of each programme of work have been implemented as per required timescales in Q2, and implementation will continue during Q3/4 aligned to national timeframes.		

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, ICB Place Director appointed and clinical GP neighbourhood recruitment commenced, this allows for a suitable partner for us to engage with appropriately.	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 ICB Place Director appointed and clinical GP neighbourhood recruitment commenced, this allows for a suitable partner for us to engage with appropriately	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 ICB Place Director appointed and clinical GP neighbourhood recruitment commenced, this allows for a suitable partner for us to engage with appropriately	Chief Strategy and Planning Officer	Q4 26/27
GA	Sustainability and population needs assessment, linked to the specialty matrix, to allow analysis of long term sustainability is not yet developed.	Complete the sustainability and population needs assessment; map findings to the specialty matrix; identify service risks, capacity gaps and priorities; agree mitigations and embed outputs in long-term planning. ICB Place Director appointed and clinical GP neighbourhood recruitment commenced, this allows for a suitable partner for us to engage with appropriately	Chief Strategy and Planning Officer	Q3 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
C5	The Trust maintains Board-approved strategic and partnership priorities with defined executive accountability, clear and agreed delegation and equal representation in key system and system governance forums.	Material collaborations are supported by formal agreements and joint governance arrangements that establish objectives, decision rights, responsibilities, benefits, dependencies, risk ownership and escalation routes, underpinned by due diligence, shared performance and risk reporting, and appropriate stakeholder engagement.	Limited
C6	Development and implementation of a Pathology Services Partnership with RDUH	Partnership governance, implementation reporting and agreed performance, quality, financial and risk measures provide oversight of delivery; assurance remains limited while arrangements embed and evidence of sustained benefits and effective risk management develops.	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 new governance structures. – *October 2026 – the Trust continues to await the new ICB joint committee Terms of reference for Board consideration. Indications this will be shared with CEO's in November for initial review.*	Chief Executive	Q3 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. *October 2026 – awaiting ICB transformation programme to be developed. ICB publication of the Case for Change anticipated in their October Board meeting.*	Chief Operating Officer Chief Medical Officer / Chief Nursing Officer	Q3 26/27 – *Deadline extended due to external factors*

GC	Lack of clear shared accountability, aligned priorities, timely information and robust cross-organisational governance upon which effective partnership and system working is dependent.	Agree shared priorities, named accountable leads, decision rights and escalation routes; implement timely joint performance and risk reporting; review delivery through system governance.	Chief Executive	Q3 26/27
GC	The absence of a Devon clinical strategy limits alignment of service priorities, investment and pathway redesign, increasing the risk of fragmented planning, duplication, delayed transformation and inconsistent outcomes across the system.	Define and approve the Trust's clinical priorities and service sustainability criteria; align investment, workforce and transformation plans to them; use these priorities to influence system strategy; and report material misalignment, dependencies and mitigations to the Board.	Chief Medical Officer / Chief Nursing Officer	Q3 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
GA	Limited analytics and assurance on the impact of external partner performance on Trust pathways, constraining oversight of dependencies and accountability for agreed delivery.	Define partner performance measures and pathway impacts; establish routine joint analytics and exception reporting; review delivery through formal governance; escalate underperformance; and track agreed recovery actions, risks and mitigations to closure.	Chief Executive / Chief Operating Officer	Q3 26/27
GA	Limited assurance on external partners' capacity, risks and delivery constraints, reducing the Trust's ability to assess dependencies, anticipate impacts and confirm delivery of agreed commitments.	Request partners provide regular capacity, risk and constraint assessments against agreed commitments; maintain a Trust dependency register; review impacts and mitigations through formal governance; escalate material concerns; and track recovery actions to closure.	Chief Executive / 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	Limited
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	Limited
C6	Established a control framework for the safe, lawful and ethical use of artificial intelligence (AI)	Approved Trust Policy, Defined governance and documentation, Committee papers	Limited
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. *October 2026 - Vacancy freeze has impacted on key appointments being made to Cyber posts, this has impacted delivery target date moved to Q4*	Chief Strategy and Planning Officer	Q4 26/27
GC / GA	Lack of clarity across Devon regarding the Target Operating Model including digital capability and capacity	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 and Executive level representation at Trust Board	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, half year assurance review completed with NHSE	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. During quarter 2 all variable pay controls have been strengthened. During quarter 3 work will continue to drive down agency spend as part of the wider workforce controls.	Chief Finance Officer / Chief People Officer	Q3 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. This work was completed in Quarter 2. Agreeing the approach with Torbay Council on transfer of debt from 1 April 2027 will take place in Quarter 3.	Chief Finance Officer	Q3 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 Finance Officer	Q2 26/27 **Completed**
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. A clear plan for delivery of performance through productivity to deliver the required level of contractual income for the year was developed in Quarter 2. During Quarter 3 and 4 the Trust will track and monitor performance activity and income to ensure the plan is delivered.	Chief Finance Officer	Q3/4 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
GA	Shared procurement service is not currently delivering agreed savings and service standards	Formal improvement plan with the shared procurement service, including measurable savings, service, compliance and milestone requirements; strengthen monthly contract and exception reporting; escalate non-delivery through joint governance; apply contractual remedies where appropriate; scope and implement contingency arrangements for critical services	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. Executive level dashboard with greater levels of trend data in creation between Epic and BI with plan to publish phase 1 in November.	Moderate
C2	Elective care recovery programme with waiting list management and validation	RTT and Patient Tracking List (PTL) review process led by the performance team; specialties requiring intervention identified. Elective recovery and improvement plan with operating plan trajectories developed and delivered. Programme governance with scheduled oversight meetings. Specialty level productivity and activity plans in progress and reviewed weekly by the COO. Each specialty has been set an RTT target to reach to deliver the end of year Trust position. September performance trajectory met.	Limited
C3	Urgent and emergency care improvement programme and flow management	Full UEC improvement plan based on 4 key pillars developed and delivered. Programme governance with scheduled oversight meetings. ED elements of plan in delivery with performance improvement evident. Unscheduled care village (SDEC) on schedule to open in October in line with plan Clear commissioning plan for care coordination re-procurement submitted to ICB as part of SDEC model.	Limited
C4	Community services capacity and demand management	Community waiting list data more visible and to be reviewed in care group delivery reviews. Counting and coding continues to be reviewed following Epic go live. Community waiting list currently meeting national NOF segment 2 levels.	Limited
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. Additional activity plans have been agreed for September and October – completed Weekly monitoring of plans now in place through weekly RTT meetings with the COO and monthly productivity oversight meetings with COO and turnaround Director.	Chief Operating Officer	~~Q2 26/27~~ Q3 26/27 Ongoing

		October 2026 - From Q3 onwards, performance is expected to deliver against agreed trajectory. Deadline extended for monitoring of delivery.		
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 and 5-point plan being created with expectations of enacting by end of September at latest. Non admitted demand plan to be in place by 15th October Long Length of stay plan in creation Unscheduled care village launch 15th October Planning form frailty phase 3 underway	Chief Operating Officer	~~Q2 26/27~~ Q3 26/27 Deadline extended in line with active project plan
GC	Activity recovery following reductions for Epic implementation is behind plan	Full review being undertaken and targeted work with consultants Sept 2026 – Productivity plan in creation for top 9 specialties linked to the operating plan Epic creating dashboards to enable real time oversight External support being resourced to enable validation of PTL to ensure accurate position Overall Trust activity has returned to pre Epic levels. Productivity plan in place for majority of specialities to recover lost outpatient activity in H1 through additional new appointments or changes to clinic profiles. Work continues with a small number of clinicians on returning to correct levels of activity.	Chief Operating Officer	~~Q1 26/27~~ Q2 26/27 **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. Specialty specific plans underway with Dermatology expected mid September and Urology, Colorectal and Gynaecology in development Specific specialty deep dives to be schedules with the Cancer Alliance Cancer waiting times have not recovered in line with trajectory set. *October 2026 - Further recovery plan developed to be delivered through Q3. Recovery funding meeting planned with Cancer Alliance to discuss what additional capacity can be procured to support recovery.* *Cancer cabinet to undertake pathway reviews to ensure all cancer pathways adhering to national best practice.*	Chief Operating Officer	~~Q2 26/27~~ Q3 26/27 Deadline extended in line with active project plan
GA	Community services performance data not consistently available	Develop community services performance framework with key performance indicators. Completed and to be presented in IQPR.	Chief Operating Officer	Q2 26/27 **Completed**

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	Freedom to Speak Up and whistleblowing arrangements are currently insufficient to meet the needs of the workforce	Strengthened independent FTSU function to be implemented. October 2026 – new FTSU service launched October 2026.	Chief People Officer	Q3 26/27
GA	Policies overdue for review — compliance rate requires improvement	Policy review acceleration programme with clear prioritisation – **Completed** *October 2026 – Full review completed however competing priorities has resulted in a number of policies not being updated and scheduled for approval. Deadline extended to allow continued monitoring. Process review undertaking and plan to strengthen and streamline policy management to be instigated during Q3*	Chief of Staff	~~Q2 26/27~~ Q3 26/27 Deadline extended to allow improvement plan to be instigated
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
GA	Limited assurance that long-standing risks are subject to sufficiently robust and sustained review and challenge, with variable quality, timeliness and consistency of evidence to demonstrate control effectiveness, delivery of mitigating actions and the rationale for current risk scores	Undertake a targeted review of long-standing risks; define minimum risk-quality and assurance evidence standards; and routinely report overdue reviews, weak assurance and exceptions through executive governance and the Audit and Risk Committee	Chief of Staff	Q4 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.	Limited

Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Transformation programme capacity — insufficient PMO resource	Strengthen PMO capability; develop delivery framework with SRO accountability	Chief Strategy and Planning Officer	Q4 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. Enforcement notice from D&SFRS means acceleration of solutions required	Chief Executive Officer	Q2 26/27 **Completed**

GC / GA	The current proposed plan for the Tower is not yet supported by a fully developed, funded and deliverable implementation plan, with confirmed milestones, dependencies, contingency arrangements and clear system-wide responsibilities. Formal assurance and commitment from Devon and Somerset Fire and Rescue Service, the ICB and NHS England remain incomplete, including confirmation that the proposed mitigations are sufficient, sustainable and supported. There is also limited quantified assurance on the wider impact of the plan on clinical capacity, patient flow, workforce, finance, service continuity and delivery of constitutional performance standards.	Finalise an integrated Tower delivery and assurance plan, including agreed milestones, funding, accountabilities, dependencies, operational contingencies and escalation triggers. Secure and document formal assurance and required support from DSFRS, the ICB and NHS England, and complete a comprehensive impact assessment covering quality, capacity, workforce, finance, service delivery and performance. Report delivery, external dependencies and emerging impacts routinely to the Board.	Chief Executive Officer	Q3 26/27
GA	No established benefits realisation framework for transformation programmes	Develop and implement benefits realisation methodology and tracking	Chief Strategy and Planning Officer	Q2 26/27 (completed)
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 (completed)

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	Financial disaggregation of integrated budgets not yet complete	Joint finance workstream to model costs and agree transfer arrangements *October 2026 – Plan in place and the Trust has completed a tabletop review of most of the cases but this has not yet been accepted by the LA*	Chief Finance Officer	~~Q2 26/27~~ Q3 26/27 Deadline extended
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 *October 2026 - Mapping of roles is complete with the exception of Hollacombe (expecting resolution week w/c 19/10/2026) and carers which is currently sat with the ICB/LA commissioners*	Chief People Officer	~~Q2 26/27~~ Q3 26/27 Deadline extended
GA	Impact on service users and carers not yet assessed	Commission independent impact assessment on service users and carers October 2026 – Equality and Quality Impact Assessments undertaken for health changes post transition. This is with the CNO and CSPO for final review	Chief Operating Officer	~~Q2 26/27~~ Q3 26/27 Deadline extended
GA	An approach to the management of delegated healthcare tasks has not been agreed which reduces oversight of competency, accountability, capacity and patient safety risks when the service is transferred to Torbay Council	Agree a joint delegated healthcare tasks framework covering scope, accountability, authorisation, competency, recording and escalation; monitor compliance, incidents and outcomes through transition governance; and address identified workforce and patient safety risks	Chief Operating Officer	Q3 26/27

GA	The potential and predicted pressures on wider system services arising from the transfer of adult social care to the Council are not yet fully understood, quantified and reflected in transition and contingency plans	Complete joint demand, capacity and pathway impact modelling with system partners for the adult social care transfer; agree scenarios, thresholds and mitigations; embed findings in transition and operational plans; escalate material system dependencies; and monitor pressures, outcomes and contingency actions through transition governance and Board reporting	Chief Operating Officer	Q3 26/27

NHS
Torbay and South Devon
NHS Foundation Trust

Corporate Risk Register

2026/2027

October 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	158	8	► Stable	Above appetite
Infection Prevention and Control	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	9	15	1	► Stable	Above appetite
Health and Safety	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	12	70	4	► Stable	Above appetite
Workforce, Inclusion and Education	People and Culture	Moderate (Low for EDI)	12	57	5	► Stable	Above appetite
Legal and Regulatory	Leadership and Governance	Very Low	12	14	2	► Stable	Above appetite
Communication and Reputational	Leadership and Governance	Very Low	12	9	1	► Stable	Above appetite
Performance	Performance	Low	12	39	3	► Stable	Above appetite
Estates and Facilities	Finance	Low	12	38	2	► Stable	Above appetite
Financial	Finance	Low	16	17	3	► Stable	Above appetite
Strategy and Transformation	Strategy and Business	High	16	3	2	► Stable	Within appetite
Business Continuity	Strategy and Business	Low	9	39	0	► Stable	Above appetite
Environmental	Strategy and Business	Moderate	12	2	0	► Stable	Within appetite
Information Governance	Digital and Data (system-aligned)	Low	9	18	0	► Stable	Above appetite
Digital, Cyber and Data	Digital and Data (system-aligned)	Low	12	46	3	► Stable	Above appetite
Partnership and System	Partnership and System	High	20	4	3	► Stable	Above appetite
Health Inequalities and Population Health	Health Inequalities and Population Health	Moderate	9	3	0	► Stable	Within appetite
Organisational Transition	Organisational Transition	Moderate	20	2	2	► Stable	Above appetite

Clinical Safety and Patient Experience

Signature Move: ***'Reimagining acute and specialist care'***

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Very Low	> 3	12	8	► Stable	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 = 158



Linked Corporate Risks

47	Principal Overarching Risk - Medical Device Rolling Replacement Programme (MDRRP)	16
233	Stroke Services (overarching risk)	16
372	EPIC Risk Assessments and Key Reporting information	16
51	Access to an Emergency Theatre for Obstetric Cases	15
62	Implementation of Thirlwall Inquiry Recommendations	15
58	Clinical Governance Team - Demand Exceeding Capacity – Urgent and Emergency Care	15
527	Delays in treatment and monitoring and comprehensive annual review of Multiple Sclerosis Patients	15
43	Delay in Mental Health Patients Being Transferred to Appropriate Placement/ Assessment Environment	12
55	Increasing Acuity Within Urgent Treatment Centre Patients	10

Commentary

Since September 2026, clinical safety and patient experience risk exposure has remained stable and above the Trust's very low appetite. The October position is an aggregate score of 12 across 158 risks, with eight rated 15 or above; the key change is the addition of the multiple sclerosis treatment, monitoring and annual review risk, while other material risks remain unchanged under enhanced 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	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Very Low	> 3	9	1	► Stable	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	Safe Care Requires a Hierarchy of Controls to Prevent and Control/ Manage the Spread of Infectious Diseases. (Overarching Risk)	15
37	Pharmacy Aseptic Services - Risk to Provision of Systemic Anti-Cancer Treatments	12

Commentary

Since September 2026, infection prevention and control risk exposure has remained stable and above the Trust's very low appetite. The October position is an aggregate score of 9 across 15 risks, with one rated 15 or above; E. coli, C. difficile and MSSA performance and QMLR data quality remain the principal concerns, with recovery actions, validation and strengthened oversight continuing.

Health and Safety

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Very Low	> 3	12	4	▶ Stable	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.

Total number of risks in category = 70



Linked Corporate Risks

92	Increased consequence of harm resulting from fire in Acute Tower Block due to sustained failure to meet Statutory Standard (CD3)	25
41	Excessive Storage of Flammable Items in Corridors for Prolonged Periods	20
227	Lack of Security Cover at Community Sites	16
182	Vulnerability of Buildings and Occupants to the Effect of a Road Traffic Collision	15

Commentary

Since September 2026, health and safety risk exposure has remained stable and above the Trust's very low appetite. The October position is an aggregate score of 12 across 70 risks, with four rated 15 or above; the acute tower fire risk, corridor storage, community-site security and road-traffic collision exposure remain the principal priorities under statutory and executive oversight.

Workforce, Inclusion and Education

Signature Move: ›Caring?skilled.people.ready.for.tomorrow"

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Moderate (Low for EDI)	> 12	12	5	► Stable	Above appetite

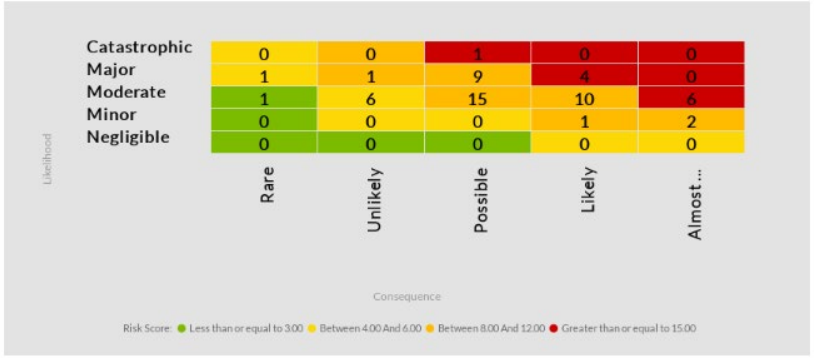
Overarching Risk Statement

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

Total number of risks in category = 57



Linked Corporate Risks

44	Insufficient Permanent Workforce Capacity to Meet Patient Need (Overarching Risk).	16
49	Shortage of Therapeutic Radiographer and Support Workforce (Radiotherapy)	16
569	Single Site Specialist for Breast Radiotherapy	16
196	Lack of Capacity due to Inadequate Staffing Levels- Haematology	15
572	Totnes Hospital Staffing levels	15
48	Systematic Anit-Cancer Therapy Nursing Capacity on Ricky Grant Day Unit and Turner Ward (Nursing & Midwifery Workforce Risk)	9
158	There is a risk that sexual safety incidents are not consistently prevented, identified, escalated, investigated, and earned from across the organisation	9

Commentary

Since September 2026, workforce risk exposure has remained stable and above the Trust's moderate appetite, and low appetite for EDI. The October position is an aggregate score of 12 across 57 risks, with five rated 15 or above; specialist vacancies and permanent workforce capacity remain the main pressures. Ward establishment and recruitment reviews, tighter workforce controls and agency/bank scrutiny are progressing, the sexual safety audit actions are closed, and wellbeing plans are being implemented.

Legal and Regulatory

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Very Low	> 3	12	2	► Stable	Above appetite

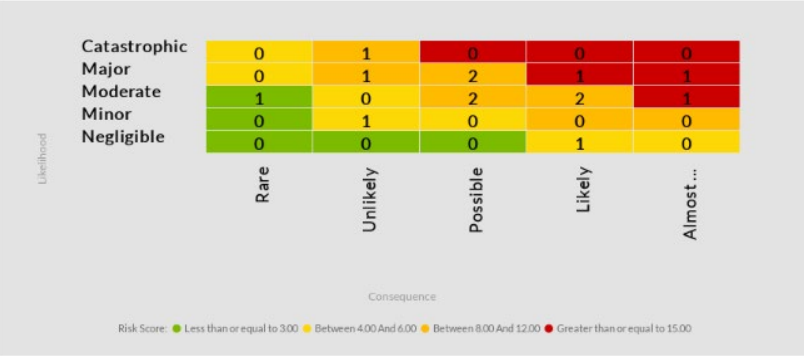
Overarching Risk Statement

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 = 14



Linked Corporate Risks

320	Risk Management Support, Exceeding Capacity-Single Point of Failure	16
366	Non-compliance with Freedom of Information and Subject Access Requests	15
180	Trust Wide Oversight of Legal and Regulatory Compliance via robust governance and risk processes	10
134	Failure to protect, preserve and retrieve complete and authentic corporate (non-clinical) records	9

Commentary

Since September 2026, legal and regulatory risk exposure has remained stable and above the Trust's very low appetite. The October position is an aggregate score of 12 across 14 risks, with two rated 15 or above; FOI/SAR compliance and risk-management capacity remain the principal exposures, with leadership accountability, specialist advice, training, audit and improvement plans providing mitigation.

Communication and Reputation

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Very Low	> 3	12	1	► Stable	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 = 9



Linked Corporate Risks

609	Reputation and Stakeholder Confidence	20
392	Patient Experience Team Processing Delays	3

Commentary

Since September 2026, communication and reputational risk exposure remains increased and above the Trust's very low appetite. The October position is an aggregate score of 12 across nine risks, with one rated 15 or above; scrutiny of service change, estates, financial sustainability and future care models remains the principal exposure, with the Board-approved escalation framework and developing communications and engagement plan strengthening mitigation.

Performance

BAF Domain: Performance | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	12	3	► Stable	Above appetite

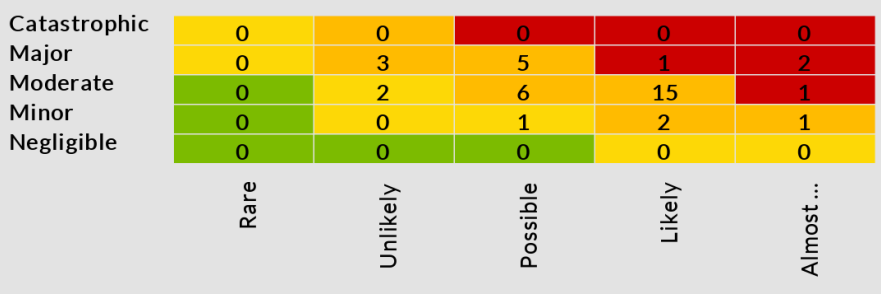
Overarching Risk Statement

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 = 39



Linked Corporate Risks

570	Referral to Treatment Times Performance Data and Waiting List Reporting	20
46	Non Compliance With The National Cancer Waiting Time Targets.	16
45	Risk to Delivery of Safe, High-Quality and Timely Care due to Persistent System Capacity Flow Constraints.	15

Commentary

Since September 2026, performance risk exposure remains stable and above the Trust's low appetite. Urgent and emergency care improved across the four-hour and 12-hour standards, ambulance handovers and corridor care, with progress continuing into October. RTT and cancer performance also improved, but remain below trajectory; post-Epic data-quality and waiting-list reporting issues have resulted in a new corporate risk. The October position is an aggregate score of 12 across 39 risks, with three rated 15 or above.

Estates and Facilities

BAF Domain: Finance | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	12	2	► Stable	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	Inability to maintain/operate the estate in accordance with customer needs, NHS Health Technical Memoranda & Statutory/Mandatory requirements within allotted resource.	25
72	Cancer Services Building Poor Condition and Capacity (CD No9)	20

Commentary

Since September 2026, estates and facilities risk exposure has remained stable and above the Trust's low appetite. The October position is an aggregate score of 12 across 38 risks, with two rated 15 or above; the maintenance backlog, constrained capital, New Hospital Programme deferral and condition of key buildings remain the main risks to safety, continuity and compliance.

Financial

BAF Domain: Finance | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	16	3	► Stable	Above appetite

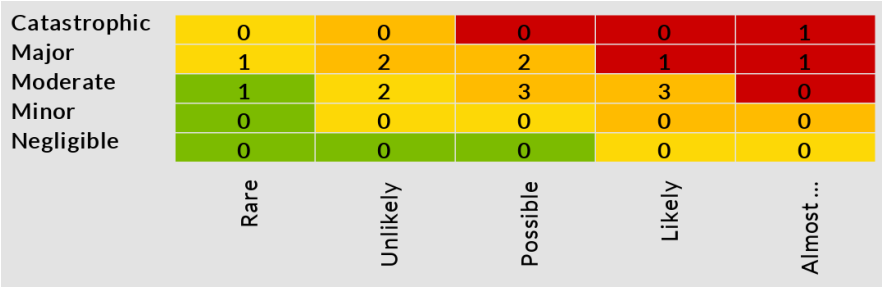
Overarching Risk Statement

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 = 17



Linked Corporate Risks

242	Financial Sustainability & Plan Delivery	25
604	Devon Procurement Service	16
243	Finance Systems and Reporting Risk	10

Commentary

Since September 2026, financial risk exposure has remained stable and materially above the Trust's low appetite. The October position is an aggregate score of 16 across 17 risks, with three rated 15 or above; financial recovery, Devon Procurement Service implementation and finance reporting remain the principal exposures, alongside active management of adult social care debt through strengthened grip and control.

Strategy and Transformation

BAF Domain: Strategy and Business | Committee: ExCo / Board (direct)

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
High	> 20	16	2	► Stable	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 = 3



Linked Corporate Risks

611	Delivery and Transition of Cellular Pathology Services to Gadeon House	20
607	Failure to deliver the Trusts strategic and transformation ambitions	16

Commentary

Since September 2026, strategy and transformation risk exposure remains increased but within the Trust's high appetite. The October position is an aggregate score of 16 across three risks, with two rated 15 or above; delivery of strategic ambitions and the cellular pathology transition to Gadeon House remain the principal exposures, with programme governance, prioritisation, dependencies and benefits realisation being strengthened.

Business Continuity

BAF Domain: Strategy and Business | Committee: ExCo / Board (direct)

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	9	0	▶ Stable	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 = 39



Linked Corporate Risks

561	Non Compliance with Business Continuity Legislation	10

Commentary

Since September 2026, business continuity risk exposure has remained stable and above the Trust's low appetite. The October position is an aggregate score of 9 across 39 risks, with none rated 15 or above; work continues to clarify risk ownership and remove duplication, alongside strengthening business impact assessments, continuity and recovery plans, supplier assurance, training and exercising.

Environmental

BAF Domain: Strategy and Business | Committee: ExCo / Board (direct)

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Moderate	> 12	12	0	► Stable	Within appetite

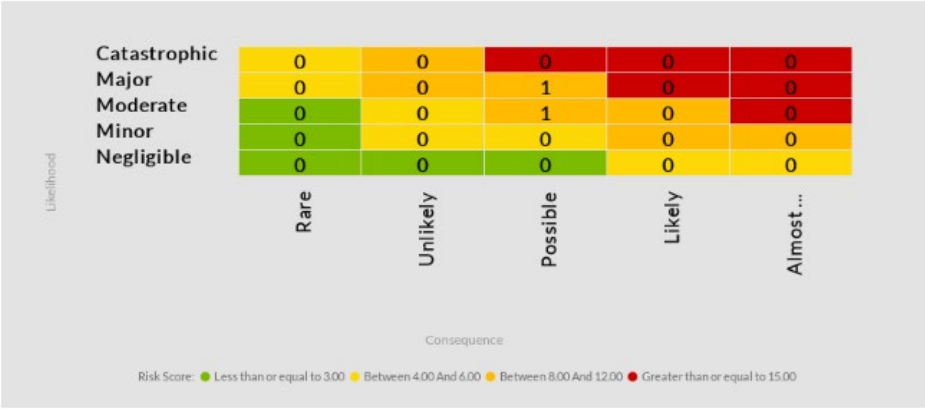
Overarching Risk Statement

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



Linked Corporate Risks

322	Trust's Failure to Achieve Objectives Set Out in the Trust's 2040 Green Plan	12

Commentary

Since September 2026, environmental risk exposure has remained stable and within the Trust's moderate appetite. The October position is an aggregate score of 12 across two risks, with none rated 15 or above; delivery of environmental and net zero commitments, resource efficiency and climate resilience remain the principal exposures under Green Plan and sustainability governance.

Information Governance

Signature Move: ›Smart.use.of.technology.for.better.care

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	9	0	▶ Stable	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.

Total number of risks in category = 18



Linked Corporate Risks

246	Data Security & Protection Toolkit Compliance	8

Commentary

Since September 2026, information governance risk exposure has remained stable and above the Trust's low appetite. The October position is an aggregate score of 9 across 18 risks, with none rated 15 or above; data protection, records management, information sharing and workforce awareness remain the principal exposures, with continuing complexity from Epic migration and integrated services managed through established IG controls and DSPT delivery.

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	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Low	> 6	12	3	► Stable	Above appetite

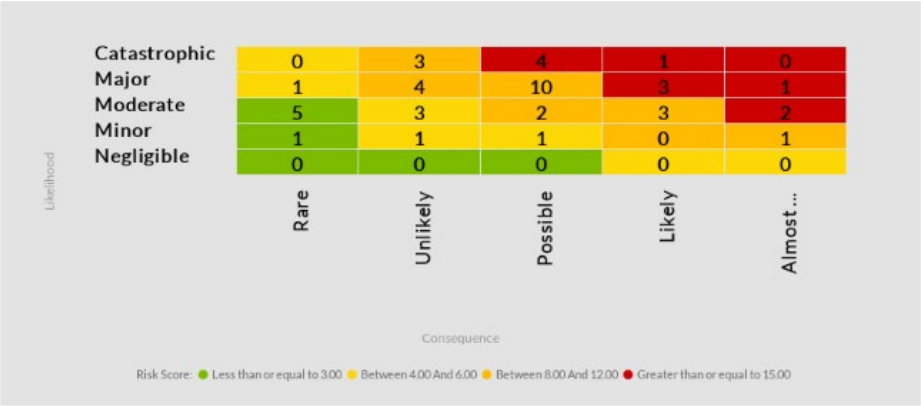
Overarching Risk Statement

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 = 46



Linked Corporate Risks

40	Current IT Systems And Infrastructure Will Not Meet Future Demands.	15
90	Potential Failure to Meet Cyber Security and Information Governance Standards Set by NHS England, and Network and Information System Regulations	15
54	Compromise or Failure of Cloud Hosted IT Services or Systems	12
325	Activity Dataset Non-Compliance For Community Setting	5

Commentary

Since August 2026, digital, cyber and data risk exposure has remained stable but above the Trust's low appetite.

The October position records an aggregate score of 12 across 46 risks, with three corporate risks scoring 15 or above. The principal exposures remain the resilience of core IT infrastructure and cloud services, 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, infrastructure and supplier oversight, business continuity arrangements, system access controls, patching and vulnerability management, and delivery of the Data Security and Protection Toolkit improvement programme. Delays in partner adoption of the Devon-wide target operating model are increasing risk to the Trust; local governance arrangements are therefore under review to strengthen mitigation and escalation.

Partnership and System

Signature Move: ›Joined_up.care?every.step.of.the.way"

BAF Domain: Partnership and System | Committee: ExCo / Board (direct)

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
High	> 20	20	3	► Stable	Above appetite

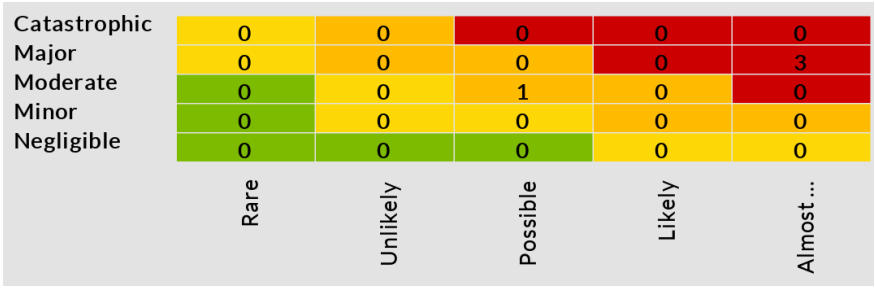
Overarching Risk Statement

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 = 4



Linked Corporate Risks

599	Potential Failure to Deliver Effective Partnership and System Working	20
608	Absence of a Devon Clinical Strategy	20
610	Development and Implementation of a Pathology Services Partnership with Royal Devon University Healthcare	20
64	Cross-Organisation Governance for Electronic Patient Record Programme	9

Commentary

Since August 2026, partnership and system risk exposure has increased and is above the Trust's high appetite.

The October position records an aggregate score of 20 across four risks, three of which are corporate risks scoring 15 or above. The principal exposures relate to 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 are reviewing these exposures to ensure material cross-organisational risks are clearly recorded, jointly owned where appropriate, supported by effective controls and actions, and escalated through agreed governance arrangements

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	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Moderate	> 12	9	0	► Stable	Within 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 = 3



Linked Corporate Risks

No Current Corporate Risks

Commentary

Since September 2026, health inequalities and population health risk exposure has increased and is above the Trust's moderate appetite.

The October position records an aggregate score of 16 across three risks, with one corporate risk scoring 15 or above. This new category is aligned with the Integrated Care System Board Assurance Framework 2026/27. A baseline assessment has been completed and existing risks mapped. Population health intelligence, inequalities metrics and governance arrangements are being developed to strengthen oversight, identify unwarranted variation and support targeted action. The current score reflects the early maturity of controls and assurance;

.

Organisational Transition

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

Appetite	Tolerance	Current Aggregate Risk Score	Corporate Risks at 15 +	Direction	Position
Moderate	> 12	20	2	► Stable	Above appetite

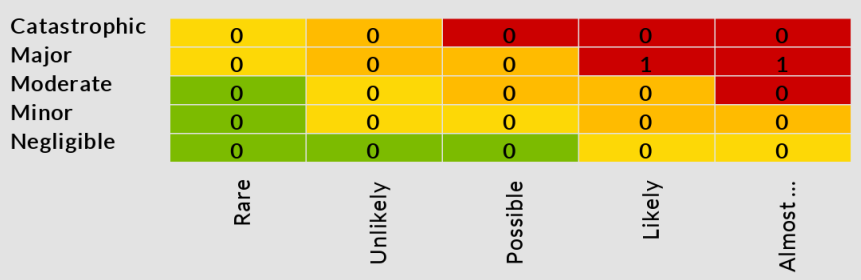
Overarching Risk Statement

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



Linked Corporate Risks

603	Transfer of Adult Social Care Bad Debt to Torbay Council	20
289	Section 75 transition: risk of service disruption, financial unsustainability or failure to agree a revised contractual framework with Torbay Council by April 2027	16

Commentary

Since August 2026, organisational transition risk exposure has increased and is above the Trust's moderate appetite.

The October position records an aggregate score of 20 across two risks, both of which are corporate risks scoring 15 or above. The principal exposures relate 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 arrangements continue to develop; however, further assurance is required that responsibilities, resources, milestones, dependencies and impacts on service users and carers are clearly understood and managed through to implementation. The financial risk arising from outstanding debt is subject to separate finance oversight. Risk scores are reviewed monthly to ensure emerging issues and changes in exposure are reflected promptly.

NHS
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NHS Foundation Trust

Presented to:	**Trust Board**					
Title of Report	Winter Plan 2026/2027					
Date of Meeting	5 November 2026		**Author**	Craig Owen, Interim Head of Operations		
Executive Lead	Sam Wadham-Sharpe, Chief Operating Officer		**Executive Sign Off**	Sam Wadham-Sharpe, Chief Operating Officer		
Governance Route	Winter Planning Group → Trust Executive Group → Trust Private Board → Trust Public Board					
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
	☒					
Executive Summary	The Torbay and South Devon NHS Foundation Trust Winter Plan 2026/27 sets out a clinically led response to pressures expected from October 2026 to March 2027. It aims to provide safe, timely and equitable care by reducing corridor care, ambulance handover delays, avoidable admissions and reducing length of stay, while protecting elective and specialist services wherever possible. More patients will be assessed and treated without admission, supported by expanded frailty, community and virtual services. Earlier discharge planning and a stronger focus on seven-day discharge will help reduce long stays. Ambulance handovers, 12-hour waits, corridor care and bed occupancy will be closely monitored, while elective, cancer, maternity, paediatric and diagnostic services will be protected wherever safely possible. Vaccination, infection prevention, safe staffing, staff wellbeing and tested emergency arrangements will support resilience. The Winter Planning Group will oversee delivery, with the Chief Operating Officer holding executive accountability and reporting to the Trust Executive Group. Daily Safety and Flow meetings, care-group governance and system coordination will monitor corridor care, handover delays, 12-hour waits, occupancy, discharge, length of stay, workforce, infection and elective delivery. Key risks include demand exceeding forecasts, mobilisation delays, workforce and infection pressures, limited bed and discharge capacity, financial constraints, adverse weather, industrial action and disruption to elective care.					
Recommendation	The Trust Board is asked to approve the Winter Plan 2026/27 and confirm that it provides an appropriate, clinically led and operationally deliverable framework for managing winter pressures, subject to continued monitoring of delivery, risk and system dependencies.					
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**
	☒	☒	☒	☒	☒	☒

Torbay and South Devon NHS Foundation Trust

How this paper supports delivery of the Strategy	The plan supports delivery of the Trust strategy by strengthening neighbourhood-based admission avoidance and discharge, improving acute and specialist flow, supporting staff readiness and wellbeing, coordinating care across organisational boundaries, using digital capability to improve operational oversight, and maintaining safe, resilient services throughout winter.				
Board Assurance					
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**		
BAFPF	CR46	20	Provides assurance that arrangements are in place to mitigate winter-related operational, quality, workforce and capacity risks through defined governance, daily oversight, escalation processes and system coordination.		
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	☒	☒	☒	☒	☒
Compliance / Regulatory Requirements	Supports delivery of national and system winter planning expectations, including Board assurance, urgent and emergency care performance, infection prevention and control, safe staffing, emergency preparedness, discharge and capacity management, and maintenance of safe elective services.				
Ethical or EDI implications?	The Equality and Quality Impact Assessment identifies overall benefits for safety, experience and equity. Mitigations are included for people who may be affected by disability, communication needs, digital exclusion, transport constraints, rurality or deprivation. Delivery should continue to monitor differential impacts and ensure reasonable adjustments and accessible alternatives are available.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
		☒			
Assurance rationale	Moderate assurance is proposed. The plan is clinically led, has defined executive accountability and governance, and includes daily and care-group monitoring against key operational, quality, workforce, infection and elective measures. Residual uncertainty remains because delivery depends on demand, mobilisation, staffing, bed and discharge capacity, finance, weather, industrial action and wider-system performance.				
Appendices	Appendix 1 – TSDFT Winter Plan 2026/27				

Summary

Overall Objective:

To provide safe care, reduce corridor care and ambulance handover delays, avoid unnecessary admissions, shorten length of stay, accelerate discharge and protect planned and specialist services.

The Trust's main winter mitigation will be provided through the 4 key flagship elements of the Urgent & Emergency Care (UEC) plan which are

- Emergency Department (ED) Non Admitted Plan
- Unscheduled Care Village
- Frailty Unit Expansion
- Length of Stay (LOS) Plan

These plans continue to be developed in line with the getting it right first time (GIRFT) expectations and as such, full impact modelling is not yet available. The winter plan will be updated as these plans come to fruition.

National Context and Requirements

National expectations require a clinically led, deliverable winter plan aligned to the Board Assurance Statements, including vaccination, ambulance handovers within 45 minutes, improved flow, elimination of corridor care, reduced 12-hour waits, and LOS and tested surge arrangements.

Learning from Winter 2025/26

Debrief completed and documented. Data review – operational pressures escalation level (OPEL) 3, with intermittent OPEL 4 periods. Demand was relatively stable but as expected increase in Respiratory infections. Limited increases in admissions however increase in LOS.

Demand and Respiratory Modelling

ED activity is expected to remain at a consistently high baseline, with emergency admissions generally between 65 and 75 per day unless admission avoidance improves.

7.4% of the total system bed capacity.

Infection – COVID – Oct, RSV – Nov, Flu Dec/Jan – Review of Australia Flu season current year has seen relatively low demand compared to recent years**.**

Torbay and South Devon NHS Foundation Trust

Response to the challenge:

Eliminating Corridor Care Programme

Eliminating Corridor Care Programme is organised around Right Care, Right Pathway, Right Flow and Right Coordination.

Medicine and Urgent and Emergency Care

The Medicine and Urgent and Emergency Care Group will prioritise faster front-door flow, admission avoidance, earlier senior decision-making and rapid streaming to the most appropriate clinician or pathway. Delivery will align with national emergency and acute care models and GIRFT recommendations, supported by workforce development and stronger frailty and specialty interfaces.

Key actions include optimising Newton Abbot Urgent Treatment Centre, with booked appointments planned by the end of September 2026, and launching enhanced non-admitted pathways on 15 October 2026. Earlier specialty streaming, clinically appropriate redirection and practitioner-led diagnostics will aim to improve four-hour performance for non-admitted patients by 10 % by 31 October 2026.

Each specialty will implement a queue-management plan from mid-October, including use of hot clinics and alternative clinical spaces. A standalone SDEC service within the wider Unscheduled Care Village will launch on 15 October 2026, operating Monday to Friday, 08:00–20:00, to support rapid assessment, treatment and discharge without default inpatient admission.

Targeted specialty measures include a weekday cardiology multi-disciplinary team (MDT) pilot, weekly respiratory assessment, additional respiratory consultant cover over the Christmas and New Year period and expanded cardiology hot clinics. Subject to funding and recruitment, a Heart Failure Virtual Ward will provide a further admission-avoidance and early supported-discharge pathway.

Together, these changes are intended to reduce avoidable admissions and short stays, improve four-hour performance, accelerate specialist decisions and discharge, and reduce pressure on emergency and inpatient capacity.

Frailty Transformation

The plan expands the existing Harbour and Harbour@Home across winter with the aim to move to 7 days but that is not expected until end part of the winter.

Community X-ray and the ambulatory head injury pathway will support more patients avoid ED. The current growth plan is expected to support approximately five to seven patient episodes per day.

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Planned Care and Surgical Flow

Protect day-case and elective capacity, maintain RTT and cancer pathways, increase Surgical Receiving Unit capacity via the new Surgical admission unit. Increase Trauma capacity via Ella Rowcroft and action a test of change from 29 September converting a bay of 4 into a neck of femur (NOF) assessment bay, oncology same day emergency care (SDEC), Gastroenterology (Gastro) speciality ward round in ED daily, 7 day alcohol care team and day-case productivity are key areas.

Clinical Support Services

Imaging, mobile X-ray, the Community Diagnostic Centre (CDC), point-of-care (POC) testing and mortuary arrangements support patient flow and admission avoidance. However, microbiology and

POC testing present financial pressures, and imaging equipment resilience remain an ongoing risk.

Paediatric Services

Paediatric plans focus on joint working between ED, Short-Stay Paediatric Assessment Unit (SSPAU) and inpatient services, new Internal Professional Standards, respiratory preparedness

Women's Health

Maternity will use the regional escalation framework to manage capacity, acuity and workforce pressures. Gynaecology will protect cancer and urgent pathways, use outpatient and day-case care where possible.

Community Services

Community priorities are to expand Urgent Community Response (UCR) and Frailty Virtual Ward access to block beds, protect UCR capacity, strengthen Discharge to Assess (D2A), and increase use of Jack Sears and Mapleton. Improve UCR performance to 94%, achieve 80% block-bed occupancy and get to 8–12% NCTR.

Pre-Christmas Occupancy Reduction

The Trust intends to reduce occupancy to 92% during December through admission avoidance, accelerated discharge, reduction in long stays, increased Pathway 0 discharge and maximum use of community, virtual and intermediate-care capacity.

Emergency Preparedness, Resilience and Response (EPRR)

Plans reviewed pre-Winter, including adverse weather and industrial action.

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Operational Leadership and Escalation

Enhanced seven-day site leadership will operate from 08:00 to 20:30, supported by 24/7 Clinical Site Managers and established on-call arrangements. Safety and Flow meetings will take place five times daily. OPEL, full-hospital, surge and super-surge arrangements remain the principal escalation framework.

System Coordination and Mutual Aid

The Trust will participate in NHS Devon system calls, share capacity and risk information, request mutual aid and coordinate responses to ambulance delays, discharge constraints, mental-health delays and system pressure.

Discharge Coordination and Patient Transport

Daily discharge coordination will support early identification of barriers and Home First pathways. Patient transport remains a constraint: fewer than 10% of inpatient journeys are booked in advance, complex transfers may require multiple crews and timed collections reduce flexibility.

Workforce Resilience

Nursing staffing will be overseen through twice-daily reviews, acuity tools, professional judgement and bank-before-agency controls. Medical rota changes increase daytime and weekend discharge capacity. Allied Health Professional (AHP) developments include a dedicated Joint Emergency Team (JET) physiotherapist and earlier mobilisation and discharge planning.

Vaccination

The programme aims to improve staff flu vaccination by 2.5–5%, subject to national review. Delivery will include a dedicated team, peer vaccinators, ward-based vaccination, clinics, community provision, night vaccination and targeted communications.

Focus will include patients going to new care home placement on discharge.

Infection Prevention and Control

Seven-day Infection Prevention and Control (IPC) coverage, Epic surveillance, side-room review, outbreak meetings, microbiology support, personal protective equipment (PPE) assurance and 24/7 deep cleaning will support flow and outbreak management. Limited single-room capacity remains a structural constraint.

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Estates and Facilities

On-call estates, facilities, security, community maintenance and specialist deep-cleaning arrangements are in place. Essential safety works and infrastructure failures could reduce the acute bed base and widen the winter bed gap

Staff Wellbeing

The plan treats wellbeing as a patient-safety intervention. Priorities include protected breaks, fatigue management, supervision, reflective practice, psychological support, manager training and proactive monitoring of sickness, burnout and access to support.

Communications and Engagement

Communications will support admission avoidance, appropriate service use and vaccination. Messaging will be targeted, tested with staff and communities, coordinated through a One Devon approach and adapted in response to operational pressure.

Emerging Risks

The highest residual risks include ED demand, no criteria to reside (NCTR) and delayed discharge, estates-related bed loss, workforce absence, infection outbreaks, elective disruption, financial pressure and Adult Social Care transition. Risks have proposed controls and residual scores but require owner validation and continued review.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Board of Directors**			
Title of Report	Our Plan for Better Care			
Date of Meeting	5th November 2026	**Author**	Deputy 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 (OPFBC), the Trust's transformation programme underpinning delivery of the 2026/27 Operational Plan and wider strategic objectives. The programme is structured across five transformation domains aligned to the Trust's strategy and signature moves, with clear Executive accountability through Senior Responsible Owner (SRO) governance. OPFBC continues to contribute £20.9m towards the Trust's £54.4m CIP target, representing 38% of the overall programme. During the reporting period, OPFBC Oversight approved the closure of the Frailty Expansion workstream, with remaining deliverables transferring to the UEC Recovery Programme. The programme currently monitors 59 open deliverables, with 68% rated on track or in planning and 14 deliverables completed to date. Capacity constraints continue to impact a small number of workstreams, most notably the Clinical Services Review and Productivity Improvement programmes. Work is underway to further align programme activity with organisational priorities, including a review of the Neighbourhood Infrastructure and Support workstream to strengthen ownership, priorities and governance arrangements. The SBS go-live date has been confirmed for April 2027, enabling delivery plans to be re-baselined and business readiness activity to progress. Overall, the programme is assessed as providing Limited to Moderate assurance, reflecting effective governance and oversight alongside ongoing challenges relating to capacity, delivery timescales and benefits realisation.			

<table>
<tr><td>Recommendation</td><td colspan="6">

Note progress in the delivery of Our Plan for Better Care, including workstream closures, transfer of remaining deliverables and alignment with the Trust's strategic, operational and financial priorities.
Review and take assurance from the reported programme position, including delivery performance, CIP contribution, and the actions being taken to address capacity constraints, delivery risks and benefits realisation.
Support the continued reprioritisation and alignment of transformation activity to organisational priorities, including the refocusing of the Neighbourhood Infrastructure and Support workstream.
Agree the overall assurance rating of Limited to Moderate Assurance, recognising the strength of programme governance and oversight alongside ongoing challenges relating to capacity, delivery timescales and realisation of benefits.

</td></tr>
<tr><td rowspan="2">Link to Strategic Signature Moves</td><td>Living well in our neighbourhoods</td><td>Reimagining acute and specialist care</td><td>Caring, skilled people ready for tomorrow</td><td>Joined up care, every step of the way</td><td>Smart use of technology for better care</td><td>Foundation</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td colspan="6">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.</td></tr>
<tr><td colspan="7">Board Assurance</td></tr>
<tr><td>BAF Ref</td><td colspan="2">Principal Risk</td><td>Current Score</td><td colspan="3">Impact of this paper</td></tr>
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<tr><td></td><td colspan="2"></td><td></td><td colspan="3"></td></tr>
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<tr><td>X</td><td colspan="2">X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Compliance / Regulatory Requirements</td><td colspan="6">N/A</td></tr>
<tr><td>Ethical or EDI implications?</td><td colspan="6">N/A</td></tr>
<tr><td rowspan="2">Assurance rating</td><td>Significant</td><td colspan="2">Moderate</td><td>Limited</td><td colspan="2">Inadequate</td></tr>
<tr><td></td><td colspan="2">X</td><td>X</td><td colspan="2"></td></tr>
<tr><td>Assurance rationale</td><td colspan="6">The programme is assessed as providing Limited to Moderate Assurance, reflecting effective Executive oversight, robust governance arrangements and continued delivery of key</td></tr>
</table>

	transformation objectives. Assurance is moderated by capacity constraints and delivery dependencies affecting a small number of workstreams; however, mitigations are in place and the programme remains aligned to delivery of the Trust's strategic, operational and financial objectives.
Appendices	Annex 1: Our Plan for Better Care Oversight Assurance Report October 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. Since approval of the Plan, the *Joined-up Care, Every Step of the Way* domain has closed, with completed deliverables realised through OPFBC and remaining activity transferred to other programmes.

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

2.3 Following ongoing review of the OPFBC portfolio to ensure alignment with organisational priorities, work continues to consolidate related activity, reduce duplication and focus resources on areas of greatest strategic, operational and financial impact. OPFBC Oversight approved the closure of the Frailty Expansion workstream, with remaining deliverables transferring to the UEC Recovery Programme through the Eliminating Corridor Care workstream. A formal handover of associated RAID, KPI and performance information will support continuity of delivery, governance and assurance arrangements.

2.4 OPFBC Oversight has endorsed a review of the Neighbourhood Infrastructure and Support workstream to ensure neighbourhood ownership, priorities and delivery arrangements are clearly defined. As a result, the workstream is being refocused, with refreshed deliverables and governance arrangements to be developed while

delivery continues through neighbourhood and Integrated Neighbourhood Team (INT) structures. A dedicated deep-dive review involving key stakeholders is scheduled for the next INT Programme Board in early November to agree the future direction and delivery approach.

2.5 Capacity constraints continue to limit the pace and scope of the Clinical Services Review. Delivery remains focused on Trauma & Orthopaedics as the highest-priority service area, with executive oversight required to support improvement delivery, benefits realisation and risk management. Emergency Medicine is the next priority area, while Women's and Children's Services continue to progress through a local improvement plan. Findings from the sustainability reviews will inform the next phase of the Clinical Services Review and future service priorities.

2.6 Care Group productivity improvement plans are now embedded within specialty action plans, with stronger clinical engagement driving clinic template redesign and forecast activity and financial benefits. Progress continues across Outpatients and Medical Staffing, including full utilisation of Bookwise licences, expanded productivity reporting, resumed job planning and completion of initial workforce analysis. September DNA performance remained below target at 4.9%, while further opportunities are being progressed through clinic variation reviews and capacity optimisation, although wider medical staffing review activity remains constrained by capacity. The next phase will focus on tracking and reporting activity and financial benefits through QPAGs and FDG, alongside finalising detailed deliverable and milestone plans for the Theatres and Diagnostics workstreams

2.7 The revised SBS go-live date has been confirmed for April 2027, enabling the programme to re-baseline delivery plans, align key dependencies and progress implementation readiness. TSDFT will continue data quality, cleansing and submission activity to maintain programme momentum and support a successful go-live.

2.8 The programme is currently monitoring 59 open deliverables, with 68% rated on track or in planning, 17% off track and 15% on hold. Fourteen deliverables have been completed to date, with 9 of the 10 deliverables due during the reporting period achieved. The remaining deliverable, relating to the HIN SW/NHSE partnership agreement, is progressing through final approvals and is expected to complete in October. Two deliverables have been reprofiled following SRO approval: Digital First consultation modality choice activity due to capacity constraints, and the Cultural Transformation Phase 2 restructure to December 2026 to support staff matching, recruitment activity and associated job description approvals.

3 CIP Delivery Assessment

3.1 As previously reported, delivery of this transformation programme remains critical to achieving the Trust’s Operational Plan for 2026/27 and subsequent years. Achievement of key operational targets across finance, workforce and performance continues to be dependent on the successful implementation of Our Plan for Better Care.

3.2 Our Plan for Better Care contributes £20.9m towards the Trust’s £54.4m Cost Improvement Programme (CIP) target for 2026/27. The programme is forecasting

delivery of £15.7m against its £20.9m contribution, a £5.2m shortfall. This shortfall is currently offset through additional Care Group schemes developed during the year. Overall, the Trust remains forecast to achieve its £54.4m CIP target, although delivery of a proportion of the remaining savings is dependent on schemes currently assessed as medium or high risk. Table 2 summarises the CIP position by workstream.

Reviews of higher-risk schemes are underway to strengthen delivery confidence and mitigation plans. While recurrent delivery remains below target, additional non-recurrent savings are forecast to support achievement of the overall CIP target.

3.3 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	£ -	£ -	£ 626,530	£ -	£ -	£ 626,530	-£ 594,470
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 176,242	£ 50,000	£ 126,242	£ -	-£ 1,032,238
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 189,251	£ -	£ -	£ -	£ -	£ -	£ -	-£ 189,251
1.5 Adult Social Care Transition	£ 11,390,000	£ 7,855,417	£ 1,955,979	£ 2,547,055	£ 6,687,128	£ 500,000	£ 2,124,238	£ 4,062,890	-£ 1,168,289
2.2 Improving Productivity	£ 1,150,000	£ 650,000	£ 375,000	£ 750,000	£ 750,000	£ -	£ -	£ 750,000	£ 100,000
4.2 Epic implmentation & benefits including MyCare	£ 5,656,312	£ 5,313,823	£ 1,265,277	£ 2,057,661	£ 4,253,096	£ 369,164	£ 1,784,917	£ 2,099,015	-£ 1,060,727
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ 125,015	£ 896,546	£ 1,110,233	£ -	£ 213,687	£ 896,546	-£ 1,786,367
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ 8,830	£ 69,628	£ 2,078,628	£ 225,000	£ 1,400,000	£ 453,628	£ 504,628
Our Plan for Better Care Total	**£ 25,499,907**	**£ 20,908,571**	**£ 3,730,101**	**£ 6,320,890**	**£ 15,681,857**	**£ 1,144,164**	**£ 5,649,084**	**£ 8,888,609**	**-£ 5,226,713**
Other Non Pay - Procurement	£ 1,915,000	£ 1,717,511	£ 532,025	£ 1,134,658	£ 1,984,362	£ 257,000	£ -	£ 1,727,362	£ 266,851
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,461,316	£ 600,000	£ 600,000	£ 2,459,853	£ -	£ -	£ 2,459,853	-£ 1,463
Other Care Group Schemes	£ 24,404,877	£ 29,332,366	£ 11,620,889	£ 17,101,309	£ 34,293,691	£ 2,072,000	£ 6,497,397	£ 25,724,294	£ 4,961,325
Total	**£ 54,419,784**	**£ 54,419,764**	**£ 16,483,015**	**£ 25,156,857**	**£ 54,419,763**	**£ 3,473,164**	**£ 12,146,481**	**£ 38,800,118**	**-£ 0**

4 Improvement focuses in month

4.1 In-month focus has remained on the consolidation and closure of OPFBC workstreams, supported by structured handovers of CIP activity, RAID logs, KPI reporting and governance documentation. This approach is strengthening alignment with organisational priorities, reducing duplication, addressing capacity constraints and ensuring resources are focused on areas of greatest strategic and operational impact.

4.2 Despite reduced PMO capacity, the reporting period has focused on strengthening programme assurance through the validation and collation of evidence for completed deliverables. This is ensuring that reported delivery is supported by a robust evidence base and audit trail, strengthening reporting accuracy, governance oversight and confidence in programme performance.

4.3 Looking ahead, a stakeholder deep-dive into the Neighbourhood Infrastructure and Support workstream will be undertaken through the INT Programme Board in early November to inform refreshed deliverables, delivery arrangements and governance. In parallel, initial discussions on the next phase of OPFBC will commence, focused

on aligning 2027/28 objectives with organisational priorities, existing improvement programmes and CIP requirements, ensuring resources are targeted towards areas of greatest strategic and operational impact.

5 Assurance recommendations and summary

5.1 The Board of Directors are invited to:

- **Note** progress in the delivery of Our Plan for Better Care, including workstream closures, transfer of remaining deliverables and alignment with the Trust's strategic, operational and financial priorities.

- **Review and take assurance** from the reported programme position, including delivery performance, CIP contribution, and the actions being taken to address capacity constraints, delivery risks and benefits realisation.

- **Support** the continued reprioritisation and alignment of transformation activity to organisational priorities, including the refocusing of the Neighbourhood Infrastructure and Support workstream.

5.2 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 - Moderate

Torbay and South Devon NHS Foundation Trust

Presented to:	Board of Directors			
Title of Report	Torbay Hospital Tower Block: Fire Safety Improvement Programme			
Date of Meeting	05.11.2026	**Author**	Dawn Butler Director Estates and Facilities Management Nina Kamalarajan Head of Improvement	
Executive Lead	Joe Teape	**Executive Sign Off**	29.10.2026	
Governance Route	Executive Fire Safety Oversight Group			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		X		
Executive Summary	Fire safety risks in the Tower Block have been recognised, actively managed and reported to the Board over a number of years. The age, design and condition of the building present challenges compared with modern fire safety standards and this has informed our risk management, investment and longer-term plans for the hospital estate. When the Board last received a public update in September, an extensive range of measures was in place to manage the risk. These included fire risk assessments and improvement work, fire safety checks and maintenance, fire doors and compartmentation work, emergency evacuation plans, staff training, patient dependency assessment and practical evacuation exercises. Further work to strengthen fire safety was continuing and £1.8 million had been secured for the next phase of improvements. No formal enforcement notices were in place at that time. There have been significant developments since then. On 02 October 2026, Devon and Somerset Fire and Rescue Service (DSFRS) issued an Enforcement Notice relating to evacuation arrangements on levels 4 to 8 of the Tower Block. Separately, the Care Quality Commission issued a Section 29A Warning Notice on 07 October 2026 relating to our oversight of fire safety. We have continued the controls already in place and introduced further measures to reduce risk. These include strengthened fire response arrangements, further action around patient dependency and placement, changes to how parts of the Tower Block are used and a programme of temporary service moves to reduce occupancy. The Fire Service has confirmed that recent changes have reduced risk, while further action remains necessary to meet the requirements of its Enforcement Notice. The compliance deadline has been extended from 06 November to 18 December 2026.			

	The temporary service changes will take place during November and early December. Most of the services affected will move within Torbay Hospital, with one service moving temporarily to Totnes Community Hospital. No services are closing and all will remain within Torbay and South Devon. The plan is intended to meet the requirements of the Fire Service Enforcement Notice, but this remains dependent on completing the changes and providing sufficient evidence that the revised evacuation arrangements are safe and sustainable. Against that position, the Board is asked to support continued occupation of the Tower Block as a dynamic and conditional risk decision balancing the fire safety risk against the clinical and system consequences of removing inpatient bed capacity without the corresponding mitigations being in place. Continued occupation remains subject to the enhanced safeguards and active risk reduction set out in this report alongside continued close oversight. We have also secured a further £8 million for fire safety improvements, in addition to the £1.8 million secured in September. This will support substantial work to improve fire compartmentation. The current programme anticipates work beginning on the first ward floor in spring 2027 and overall completion by February 2028, subject to the final Fire Strategy and the necessary building safety approvals. These works are necessary because the Tower Block will remain in use for several years. They do not remove the need to replace the ageing building. The longer-term plan remains to replace the inpatient accommodation currently provided in the Tower Block through the New Hospital Programme. The actions already taken are reducing risk, but the underlying limitations of the building have not been removed, and the regulatory processes remain active. The Trust submitted formal representations in response to the CQC Section 29A Warning Notice on 20 October 2026. These have been acknowledged and will be considered through the CQC's National Representations Team process, with an outcome expected by 17 November 2026. Fire safety improvement and assurance work is continuing alongside this process.
Recommendation	**Board Assurance:** The Board is asked to: • note the material developments since its last public update in September 2026, including formal regulatory action by Devon and Somerset Fire and Rescue Service and the Care Quality Commission;

<table>
<tr><td></td><td colspan="6">

- note the extensive fire safety controls and mitigations which remain in place and the further measures introduced since September;
- note the temporary service changes being implemented to reduce the number of people being cared for in the Tower Block at any one time, while maintaining as much inpatient capacity as safely possible;
- note the current regulatory position, including the further work required in response to the Devon and Somerset Fire and Rescue Service Enforcement Notice and the separate Care Quality Commission Section 29A Warning Notice;
- note the further £8 million secured for Tower Block fire safety works, in addition to the £1.8 million secured in September;
- note the relationship between the measures required now, the programme of physical fire safety improvements and the longer-term replacement of inpatient accommodation through the New Hospital Programme;
- take assurance from the governance and multi-agency arrangements overseeing the programme; and
- consider and endorse the basis on which the continued occupation of the Tower Block is being managed as a dynamic and conditional risk decision while the outstanding actions and longer-term works are completed.

</td></tr>
<tr><td rowspan="2">Link to Strategic Signature Moves</td><td>Living well in our neighbourhoods</td><td>Reimagining acute and specialist care</td><td>Caring, skilled people ready for tomorrow</td><td>Joined up care, every step of the way</td><td>Smart use of technology for better care</td><td>Foundation</td></tr>
<tr><td></td><td>x</td><td></td><td>x</td><td></td><td></td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td colspan="6">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.</td></tr>
<tr><td colspan="7">Board Assurance</td></tr>
<tr><td>BAF Ref</td><td>Principal Risk</td><td>Current Score</td><td colspan="4">Impact of this paper</td></tr>
<tr><td>BAF-ST</td><td>Control 5
Risk 92</td><td>25</td><td colspan="4">This paper evidences strengthened controls and oversight in relation to Tower Block fire safety, including enhanced evacuation arrangements, reduced occupancy and secured capital investment.</td></tr>
</table>

			Active regulatory notices, outstanding evacuation assurance and continuing dependencies on physical improvements and longer-term replacement accommodation mean significant residual risk remains. The paper does not, at this stage, provide sufficient evidence to support a reduction in the recorded risk score of 25		
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	x				
Compliance / Regulatory Requirements	The programme is intended to address the Trust's duties under the Regulatory Reform (Fire Safety) Order 2005 and the relevant Firecode and Health Technical Memorandum 05 guidance. The active Enforcement Notice means that further action and evidence are still required.				
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 Trust is in an enforcement position with DSFRS and the current plan must formally evidence to the DSFRS that it can meet the requirements of the Fire Enforcement Notice. 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 reflects the inherent limitations of the building, the active regulatory position, the further evidence required on evacuation arrangements and the fact that important elements of the risk-reduction plan and physical improvement programme are not yet complete.
Appendices	None

Torbay and South Devon NHS Foundation Trust

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 Trust's response to regulatory action.

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. Managing fire safety risk in the Tower Block

We manage fire safety in the Tower Block through a combination of measures designed to prevent and contain fire, maintain safe escape routes, support evacuation and take account of the needs of patients who may require assistance to evacuate.

These measures have been developed and strengthened over time and remain in place while further work is undertaken.

2.1 Physical fire safety measures

The programme includes fire alarm and detection systems, emergency lighting, fire suppression systems, fire doors, fire stopping and compartmentation, alongside inspection, maintenance and remedial work.

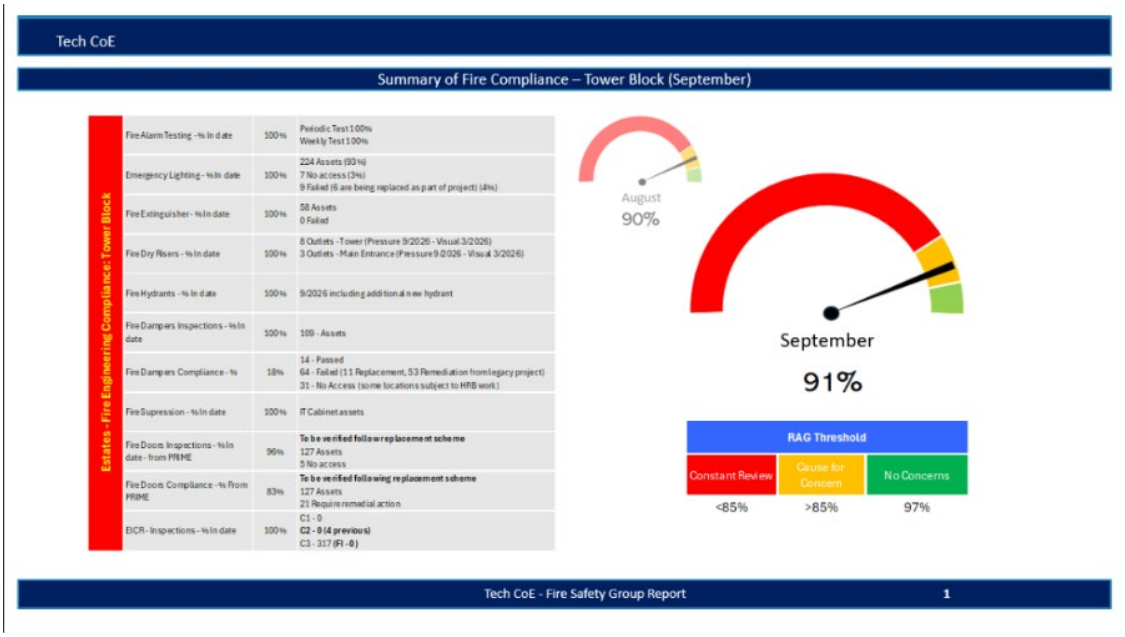
Our report to the September public Board described progress in these areas and identified where further physical improvements remained necessary. It also set out the further investment being made to improve fire safety within the Tower Block.

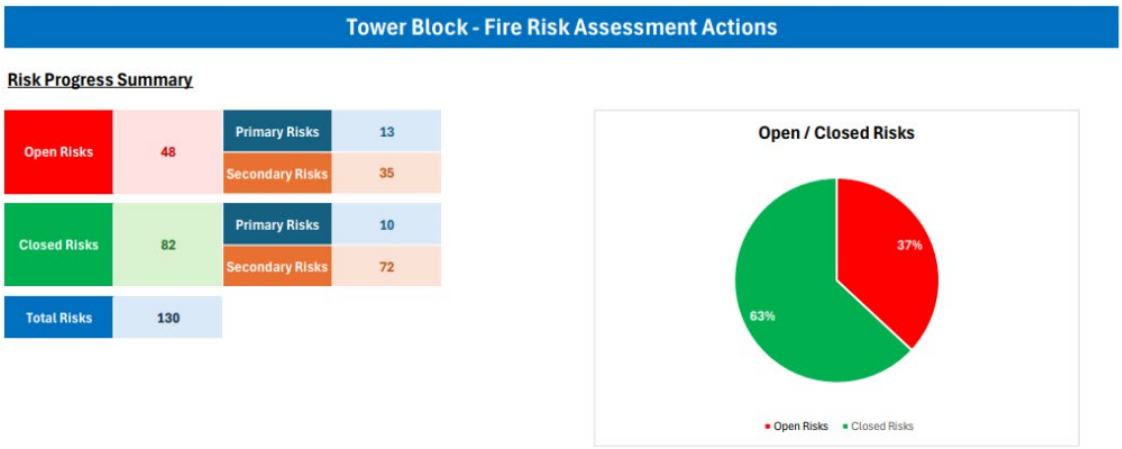
An updated fire engineering compliance position for September 2026 is illustrated below. The lowest area of compliance relates to fire dampers. Although the dampers continue to activate in the event of a fire, they do not currently meet the required inspection standard because they cannot be monitored remotely.

Tower Block fire risk assessments (FRA) action progress

The Tower Block FRA Action Log was been updated on 28 October 2026 and provides improved assurance that the actions identified in both the primary and secondary FRAs are being progressed. A substantial number of actions are subject to the Capital Fire Improvement Project.

This project is currently at RIBA Stage 3 (Design). As the works constitute a significant intervention within a Higher-Risk Building (HRB), a HRB application will be submitted prior to construction. The current programme anticipates construction beginning in spring 2027, subject to approval of the Higher-Risk Building application.





Note: this graphic shows open and closed risk

2.2 Evacuation planning, training and exercises

Each affected clinical area has arrangements setting out the action to be taken in the event of a fire, supported by Fire and Evacuation Warden training and fire safety information and resources.

Practical preparedness has been tested through exercises involving clinical and operational teams and partner agencies. The learning from these exercises has informed further training and changes to our evacuation arrangements.

The programme has increasingly focused on practical testing as well as written plans, including how quickly additional staff can be mobilised and how patients who need significant assistance can be moved safely.

Further training has continued during October. By 16 October, more than 270 colleagues working on levels 4 to 8 had received relevant fire warden and evacuation training, with further training provided to Clinical Site Managers and the Fire Response Team.

Fire and Evacuation Warden training remains a priority across the Tower Block. Completion is high on Cromie and Allerton wards, at 94% and 96% respectively**.** The current 74% completion rate on Midgley Ward reflects the ward's recent recruitment of new team members, who will complete the required training as part of their onboarding over the next few weeks.

Training is also under way for the new Discharge Lounge workforce, while practical preparedness has been strengthened through fire-extinguisher training, evacuation walkthroughs and three out-of-hours exercises.

2.3 Fire response arrangements

Fire response arrangements have been strengthened further during October, particularly overnight.

Two dedicated fire marshals patrol the Tower Block between 7pm and 7am, checking escape routes, firefighting and evacuation equipment, electrical equipment, fire loading, storage and combustible waste. The immediate overnight response team has been increased to a minimum of seven people, supported by a minimum of five trained Enhanced Care Support Officers available for deployment each night.

These arrangements strengthen the initial response to an incident and the ability to mobilise additional support if evacuation is required.

The mobilisation of the Fire Response Team and dedicated fire marshals and fire-trained Enhanced Care Support Officers is being tested for efficacy as part of our evacuation simulations.

2.4 Patient placement and dependency

The support a patient would require in an evacuation is an important part of managing fire risk in the Tower Block.

Patient dependency, evacuation requirements and oxygen needs are assessed and kept under review, allowing clinical teams to consider these alongside the clinical needs of the patient when making placement decisions.

Patient dependency reviews continue at least twice daily and arrangements can be adjusted where an individual patient's needs or the overall ward position changes. These controls will continue alongside the planned reduction in occupancy.

Current assurance over controls
The extensive measures above remain an important part of the overall fire safety response. Their effectiveness is monitored through our fire safety governance arrangements, with material exceptions requiring action and escalation.

3. Developments since September 2026
There have been three principal developments since the Board's September public report.

First, the regulatory position has changed materially, with formal action by both the Fire Service and CQC.

Second, further measures have been introduced to reduce risk, including additional operational controls and an agreed programme of temporary service changes to reduce occupancy in the Tower Block.

Third, a further £8 million has been secured for the programme of physical fire safety improvements.

These developments do not replace the measures already in place. They represent a further strengthening of our response in light of the regulatory requirements and the evidence available about evacuation from the Tower Block. The regulatory action reflects the stronger evidence now available about the practical challenges of evacuating people safely from the upper levels of the Tower Block and the further assurance required that the arrangements work consistently in practice.

4. Regulatory position
4.1 Devon and Somerset Fire and Rescue Service
On 02 October, Devon and Somerset Fire and Rescue Service issued an Enforcement Notice relating to evacuation arrangements on levels 4 to 8.

Since receiving the Notice, we have continued the fire safety measures already in place and introduced further controls, including strengthened fire-response arrangements, changes to patient placement and dependency management and measures to reduce occupancy in the Tower Block.

We have continued to work closely with the Fire Service to provide evidence about our evacuation arrangements and the impact of the further measures being introduced.

The Fire Service has confirmed that recent changes have reduced risk, while further action remains necessary to meet the requirements of the Notice in full. The compliance deadline has been extended from 06 November to 18 December 2026 to allow the necessary actions to be completed.

4.2 Care Quality Commission
The Care Quality Commission issued a separate Section 29A Warning Notice dated 07 October 2026 relating to our oversight of fire safety.

We submitted formal representations to the CQC on 20 October 2026 and receipt has been acknowledged. These will be considered through the CQC's National

Representations Team process. On the basis of the CQC's usual 20-working-day aim, an outcome is currently anticipated by 17 November 2026, although there is no statutory deadline.

The outcome will either uphold our representations, in which case the Warning Notice will be withdrawn, or not uphold them. There is no provision for the representations to be upheld in part.

Work to strengthen and test fire safety arrangements has continued alongside this process. This includes ensuring that fire safety plans and procedures are clear and that there is evidence that the arrangements are being applied consistently in practice.

The Fire Service Enforcement Notice and CQC Warning Notice remain separate regulatory processes, although both form part of our overall fire safety programme.

5. Reducing occupancy in the Tower Block

Reducing the number of people being cared for in the Tower Block at any one time is an important part of the risk-reduction plan. The temporary changes have been designed to achieve this while maintaining as much inpatient capacity as safely possible.

No services are closing and all affected services will remain within Torbay and South Devon.

5.1 Same Day Emergency Care and level 4

The Trust has continued to develop Same Day Emergency Care at Torbay Hospital.

The short-stay assessment service previously provided from EAU4 is now delivered through an expanded Same Day Emergency Care service. This enables more people to receive assessment, diagnostics and treatment and return home on the same day where an inpatient admission is not required.

A 12-bed Medical Assessment Unit has also been created. The former EAU4 space on level 4 is now the discharge lounge, which is not open overnight.

5.2 Simpson, Harbourne and Midgley

The service currently provided from Simpson Ward in the Hetherington Unit at Torbay Hospital will move temporarily to Harbourne Ward at Totnes Community Hospital, bringing currently unused ward space back into use.

This will allow respiratory inpatient services currently provided from Midgley Ward in the Tower Block to move temporarily to Simpson Ward.

5.3 Hutchings Day Unit and the Horizon Centre
Services currently provided from Hutchings Day Unit on level 8 will move temporarily to the Horizon Centre on the Torbay Hospital site.

This requires some of the education and training activity currently based in the Horizon Centre to move to alternative accommodation near the Torbay Hospital site before the Horizon Centre can be adapted for clinical use. The programme includes enabling work to prepare both the Horizon Centre and the alternative accommodation, including the Centre for Health and Care Professions at the Torbay Hospital annexe.

5.4 Allerton and Cromie
For inpatient services remaining in the Tower Block, ward space will be used differently. Allerton Ward will care for people across levels 7 and 8 and Cromie Ward across levels 5 and 6.

Together, these temporary changes will reduce occupancy within the Tower Block. The detailed bed-capacity position will vary as the temporary moves are implemented, reflecting the sequencing of moves, staffing and the readiness of receiving areas. Capacity will be managed throughout the programme to maintain as much inpatient capacity as safely possible.

The arrangements will remain under review as the fire safety programme progresses.

The changes are expected to take place during November and early December 2026.

Clinical and operational teams are working through the staffing, equipment, estates, digital and other arrangements required for the changes.

6. Evacuation assurance
Safe evacuation from levels 4 to 8 is the central issue addressed by the Fire Service Enforcement Notice.

We have used fire risk assessments, modelling and practical exercises to assess evacuation arrangements. This work considers the interaction between the building, the number and dependency of people being cared for, the staff available to assist, evacuation routes and equipment, and mobilisation and evacuation times.

Practical exercises have been important in testing how the arrangements work within a clinical environment and identifying where further measures are required.

This evidence has informed the strengthening of fire response arrangements, further training, the continuing focus on patient dependency and the decision to reduce occupancy within the Tower Block.

The Fire Service has noted the progress made, including changes already implemented and the strengthened overnight response, while making clear that

these risk reductions need to be supported by a sustainable, evidence-based approach to safe evacuation.

We continue to work with the Fire Service and specialist advisers to bring together the evidence required to demonstrate that the revised arrangements meet the requirements of the Enforcement Notice.

7. Fire safety investment and physical works
In September, we confirmed that £1.8 million had been secured for the next phase of fire safety improvements in the Tower Block.

A further £8 million has now been secured. This will support substantial work to improve fire compartmentation within the Tower Block.

The detailed construction programme continues to be developed and remains subject to the final Fire Strategy and necessary building safety approvals.

On the current programme, work is expected to begin on the first ward level in spring 2027 and then progress through the Tower Block one level at a time. The first ward level is expected to be completed in summer 2027 and the second in early autumn.

This is expected to allow two full wards to return to operation while work continues on the remaining levels.

Overall completion is currently expected by February 2028.

The temporary service arrangements will be reviewed as individual phases of work are completed and it is safe for services to return.

Precise return dates cannot yet be confirmed because they depend on the sequence and completion of the works, regulatory approvals and confirmation that each area is safe to reoccupy.

8. Longer-term plan and New Hospital Programme
The investment in the Tower Block is necessary to maintain and improve fire safety while the building remains in use. It is not the long-term answer to the age, design and condition of the building.

Our longer-term plans include replacement of the inpatient accommodation currently provided in the Tower Block with a new four-ward building as part of the wider redevelopment of the Torbay Hospital site. The proposed development is intended to protect inpatient capacity while providing modern replacement accommodation.

Torbay Hospital remains part of Wave 2 of the national New Hospital Programme, with a current planned construction window of 2032 to 2035. We continue to explore opportunities to bring forward investment in replacement inpatient accommodation and other essential infrastructure.

We are therefore working across three different but connected timescales:

- now: maintaining and strengthening operational fire safety measures and reducing occupancy in the Tower Block
- over the next eighteen months: delivering compartmentation and associated fire safety improvements to support safe continued use of the building
- longer term: replacing the inpatient accommodation currently provided within the Tower Block through the New Hospital Programme.

The longer-term replacement programme cannot remove the need to manage the existing building safely until replacement accommodation is available. Equally, investment in the existing Tower Block does not remove the need for replacement.

9. Impact on patients, services and colleagues
The changes required to reduce occupancy have been developed to maintain safe clinical care and as much inpatient capacity as possible.

As outlined above, some services will temporarily operate from different locations and some colleagues will work in different areas while the fire safety work is undertaken. No services are closing and all affected services will remain within Torbay and South Devon.

Services will move only when the required clinical environment, staffing, equipment and infrastructure are in place.

Supporting colleagues
We recognise that the changes are significant for colleagues working in the services affected, particularly where teams will temporarily work from a different site or location.

Teams most directly affected have been briefed through their managers and clinical leaders as the plans have developed, with colleagues encouraged to identify practical issues, risks and concerns so these can inform implementation. We continue to work closely with staff side throughout this programme.

Public interest and engagement
We recognise the significant public interest in fire safety at Torbay Hospital and the understandable concern about what the regulatory action and temporary changes may mean for local services.

Information about the regulatory position, additional investment and temporary service changes has been made publicly available, alongside direct briefings for colleagues and people whose care is affected. We have also provided information to governors, MPs, Healthwatch, system and local authority partners and community stakeholders.

Anyone directly affected by a change in the location of their care will receive information from the teams caring for them.

We will continue to publish material developments and explain what they mean for patients and local services as the programme progresses.

Torbay and South Devon NHS Foundation Trust

10. Governance and oversight

We have further strengthened the arrangements overseeing the Tower Block fire safety programme to reflect both the regulatory position and the range of work now under way.

The Tower Fire Safety Oversight Group provides strategic oversight of fire safety risk and the overall response.

The Tactical Programme Delivery Group coordinates delivery of the temporary clinical changes and the work required to enable them, including the interaction between clinical services, workforce, estates and infrastructure.

A Multi-Agency Enforcement Co-ordination Group provides a forum for the Trust, Devon and Somerset Fire and Rescue Service, Care Quality Commission, NHS England and other partners to consider progress and the evidence supporting the regulatory response.

These arrangements provide routes for risks which cannot be resolved operationally to be escalated.

11. Current risk and assurance

The position has moved significantly since the September 2026 public report. We have maintained an extensive package of physical and operational measures and strengthened those arrangements further during October. Changes already made have reduced risk, and further temporary changes will further reduce occupancy within the Tower Block.

The Fire Service has confirmed that recent measures have reduced risk. Its Enforcement Notice nevertheless remains active and further action and evidence are required to demonstrate that its requirements have been met.

The overall position continues to require careful management and oversight. The temporary service changes are still being implemented, the physical fire safety programme will continue beyond the immediate regulatory response and the underlying limitations associated with the age, design and condition of the building therefore remain. The recorded risk score therefore remains at 25 and the assurance assessment for this report is Limited.

Continued occupation of the Tower Block remains a dynamic and conditional risk decision, balancing the fire safety risk against the clinical and system consequences of removing inpatient bed capacity without the corresponding mitigations being in place. It, remains dependent on the enhanced safeguards, active risk reduction and close oversight set out in this report.

The CQC’s Section 29A Warning Notice remains subject to the formal representations process. Our representations were submitted on 20 October and acknowledged by the CQC. Fire safety improvement and assurance work is continuing while that process is under way.

Torbay and South Devon NHS Foundation Trust

12. Conclusion

Fire safety in the Tower Block has been actively managed and subject to Board oversight over a sustained period. The formal regulatory action taken in October represents a significant development and has led to further measures to reduce risk, including temporary service changes to reduce occupancy and strengthened operational and governance arrangements.

The immediate focus is on completing the temporary changes safely and meeting the requirements of the Fire Service Enforcement Notice by 18 December, alongside the separate CQC process. The £9.8 million secured for fire safety improvements will support the next stage of physical improvements, while replacement of the inpatient accommodation currently provided in the Tower Block remains part of our longer-term plans through the New Hospital Programme.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Board of Directors**			
Title of Report	Research & Development (R&D) 26/27 mid-year report			
Date of Meeting	05/11/26	**Author**	Dr Fiona Roberts R&D Director	
Executive Lead	Dr Kate Lissett Chief Medical Officer	**Executive Sign Off**		
Governance Route	The paper has not been considered by the R&D Group before Board because of the reporting timetable			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		x	x	x
Executive Summary	This report covers Q1 and Q2 of 2026/27 and follows NHS England's Framework for NHS boards: monitoring research activity. The Trust reports 182 active studies, including follow-up, across 34 research-active specialties, supported by 60 active principal or chief investigators. Moderate assurance is proposed overall. Study set-up has improved, participant feedback is strongly positive, and external funding has been secured. However, reported national targets are not consistently achieved, and evidence on workforce resilience, equality of access and local research impact remains incomplete. Positive evidence • Study set-up within 90 days improved from 1/7 studies in Q1 (14.3%) to 10/14 in Q2 (71.4%). Small quarterly numbers mean sustained improvement is needed. • Commercial interventional recruitment reached 29 at mid-year, compared with 38 in the whole of 2025/26. Eight new studies were approved, with five more in set-up; the final year-end position is not yet known. • The Pharmacy Aseptic Unit received a £1,499,121.60 NIHR capital award, distinct from recurrent research operating income. • Among 131 survey respondents across 23 studies, 98.4% rated their experience good or very good and 92.9% would participate again. The survey response rate is not supplied. • Regional and national partnerships support research delivery, digital capability, and infrastructure development. Exceptions and evidence gaps • Study set-up remains below the reported 95% target. • Recruitment remains below the reported 80% target: commercial open studies 46% (6/13), against an England average of 51%; non-commercial open studies 49% (50/103), above the England average of 45%. • Workforce capacity and resilience concerns need to be quantified, with consequences, mitigation, owners, and deadlines. • Only one non-acute study is open, and none are in set-up. The open study recruited 12 participants against a target of seven.			

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- Current evidence is insufficient to demonstrate equitable access or systematic local research impact. Of survey respondents, 84.4% were told how they would receive study results, identifying an improvement opportunity.
- A validated full-year commercial income forecast and quantified outstanding balances are needed before financial growth can be assured.

Controls and next steps

Weekly set-up meetings, enhanced exception reporting, and reinstated portfolio reviews are operating or being implemented. Staffing, systems, and resilience are under review; income recovery is monitored regularly. The proposed action tracker at the end of the report identifies the evidence needed for follow-up. Owners and dates require agreement. Stronger assurance depends on sustained improvement and demonstrable control effectiveness.
</td></tr>
<tr><td>Recommendation</td><td>The Board is asked to receive the mid-year report; note the positive evidence and exceptions; consider and take Moderate assurance overall, recognising the limitations described; and request follow-up on the proposed improvement actions and evidence gaps at year-end.
No financial or service approval is sought. Proposed owners, deadlines, and reporting arrangements require confirmation</td></tr>
<tr><td>Link to Strategic Signature Moves</td><td>
<table>
<tr><th>Living well in our neighbourhoods</th><th>Reimagining acute and specialist care</th><th>Caring, skilled people ready for tomorrow</th><th>Joined up care, every step of the way</th><th>Smart use of technology for better care</th><th>Foundation</th></tr>
<tr><td>x</td><td>x</td><td>x</td><td>x</td><td>x</td><td></td></tr>
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</td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td>We aspire to put research where it belongs: at the heart of the patient care, we provide at TSDFT. This is fundamental in supporting local people to live well.
Strong evidence links research-active organisations with improved patient outcomes, staff retention, and quality of care. This report supports the Trust’s strategy by embedding research within routine care, improving access to innovation and new treatments, and contributing to improved health outcomes, quality of care, workforce development, and financial sustainability.</td></tr>
<tr><td colspan="2">Board Assurance</td></tr>
<tr><td>BAF Ref</td><td>Principal Risk</td><td>Current Score</td><td>Impact of this paper</td></tr>
<tr><td>n/a - none</td><td></td><td></td><td></td></tr>
<tr><td>Link to CQC Quality Statement</td><td>
<table>
<tr><th>Safe</th><th>Caring</th><th>Responsive</th><th>Effective</th><th>Well-led</th></tr>
<tr><td></td><td></td><td></td><td></td><td>x</td></tr>
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</td></tr>
<tr><td>Compliance / Regulatory Requirements</td><td>NHSE’s Framework for NHS Boards: Monitoring Research Activity (2026)
NHSEs Medium Term Planning Framework 2025
10 Year Health Plan 2025
Governments Life Sciences Sector Strategy 2025</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">Care Quality Commission – well-led domain.
Health and Care Act 2022
UK Policy Framework for Health and Social Care Research
UK Medicines for use in Clinical Trials regulations (2004), updated 2025
NIHR Performance and Operating Framework
NHS England and the NHS contract (commercial research)
NHSE’s Managing Research Finances in the NHS
UK Clinical Research Strategy, Saving Lives
Lord O’Shaughnessy Government review and recommendations.</td></tr>
<tr><td>Ethical or EDI implications?</td><td colspan="4">Research can be a way to improve access to treatments thus reducing inequities. Research activity is a fully regulated activity with strong ethical principles, foundations, and need for NHS ethics approvals.</td></tr>
<tr><td rowspan="2">Assurance rating</td><td>Significant</td><td>Moderate</td><td>Limited</td><td>Inadequate</td></tr>
<tr><td></td><td>x</td><td></td><td></td></tr>
<tr><td>Assurance rationale</td><td colspan="4">Moderate assurance is proposed.

Oversight and improvement actions are in place, and study set-up improved in Q2. However, reported targets are not consistently achieved, improvement is not yet sustained, and evidence remains incomplete on workforce resilience, equality, impact, and non-acute research.

Stronger assurance will depend on completion of actions, sustained performance, and evidence that controls are effective.</td></tr>
<tr><td>Appendices</td><td colspan="4">n/a</td></tr>
</table>

NHSE's **Framework for NHS boards: monitoring research activity** measures are split into 2 sections Part A and Part B:

Part A: Quantitative metrics

1. **90-day study set up Target:** National target (≥ 95%)

National Oversight Framework (NOF) statistics (all NIHR portfolio studies):

	No. of studies with FPFV in Q1 2026/27 within 90 days	No of studies with FPFV in Q1 2026/27	Q1 Metric	No. of studies with FPFV in Q2 2026/27 within 90 days	No of studies with FPFV in Q2 2026/27	Q2 Metric
NOF data	1	7	14.30%	10	14	71.40%

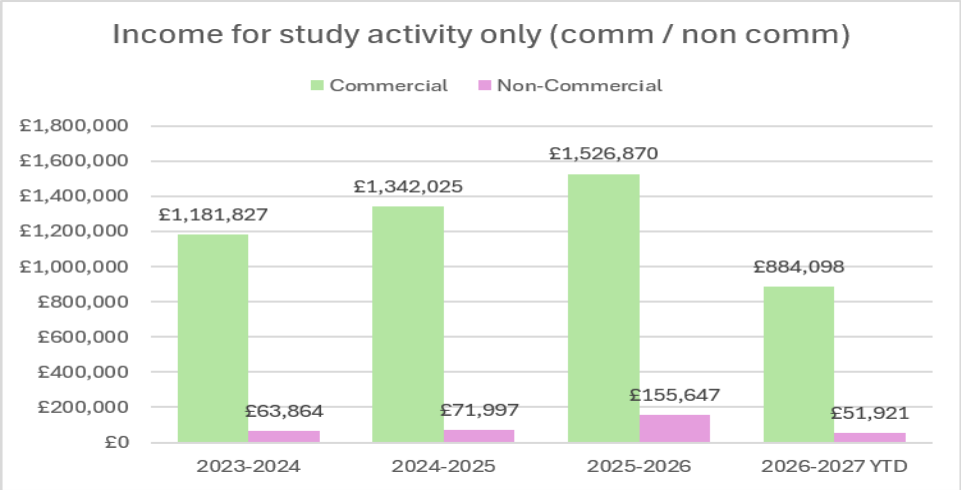
- Significant improvement made in Q2, but further sustainable improvement required.
- Weekly prioritisation and study set up meetings with all teams to look at issues earlier.
- A review of internal processes has identified data recording issues and highlighted the impact of sponsor-led delays (studies are not excluded).
- Nationally recognised data challenges regarding study start-date definitions.
- Enhanced exception reporting and revised set-up processes are being implemented to improve performance and provide greater transparency regarding the causes of delays.

2. **Recruitment to time and target (RTT) -all NIHR studies: (National target = 80%)**

TSD RTT commercial open studies on track	46% (6/13) (Eng. Avg. = 51%)
TSD RTT non-commercial open studies on track	49% (50/103) (Eng. Avg. = 45%)
TSD RTT commercial closed studies - % met target	nil (0/0) (Eng. Avg. = 54%)
TSD RTT non-commercial closed studies - % met target non-commercial	40% (4/10) (Eng. Avg. = 52%)
Recruits per 1,000 population	not available currently. R&D don't hold this data. The NIHR RDN are working on providing this data for Trusts.

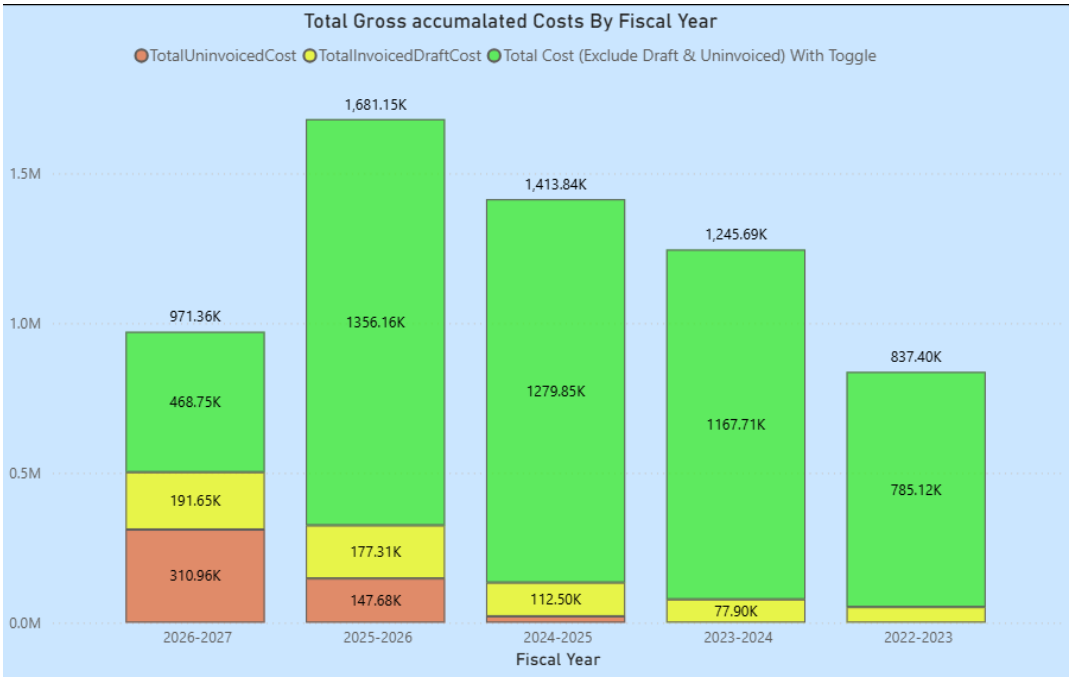
- Previously TSD has met the 80% target over the past few years. Significant improvement is needed across the remainder of 26/27. R&D has re- introduced portfolio review meetings to target underperforming studies especially in last 6 months of recruitment to focus resources to try to reverse the trend to ensure targets are met.

3. Income



- On track to surpass last year's commercial income continuing the upward trend of generating more income per annum.

Aged Cost: This graph shows the level of cost recovery versus activity undertaken. (N.B there is usually a lag time of at least 6 months from activity to able to invoice sponsors).



Key:

- *Green = income banked*
- *Yellow = invoices with sponsors awaiting final approval / payment*
- *Red = activity still not invoiced / with sponsor for source data verification.*

This is monitored and reviewed regularly to ensure cost recovery is maximised and maintained.

4. Number and Value of Grants: 2026/27 (Q1 and Q2)

Grant type	number	status	Value awarded	Award period
NIHR research grant: CHOICES-HI	1	open	£255,559.50	01/04/26-31/03/27
NIHR capital grant: Pharmacy Aseptic Unit	1	Awarded	1,499,121.60	01/11/26-31/03/28
NIHR training / development award	PCAF	Awarded and ongoing	75,630.94	01/12/25 – 30/11/27
	PCAF (new 2026)	unsuccessful	n/a	n/a
	PCAF (new 2026)	unsuccessful	n/a	n/a
	Pre-Application Support Fund (Cohort 9)	Pending outcome	n/a	n/a
NIHR -other	0	n/a	n/a	n/a
Non NIHR – TMRF grants	0	n/a	n/a	n/a
Non NIHR other	0	n/a	n/a	n/a

- Chief Investigator studies are a small proportion of R&D work. TSD is primarily a participating site, hosting research sponsored by external organisations.

5. NIHR My Research Experience survey: 2026/27 Q1 + Q2 Data (TSD)

a. proportion of participants who have been told how they will get the results of the research in which they participated = **84.4%**
b. proportion of participants who rate their overall experience in the research study in which they participated as good or very good = **98.4%**
c. proportion of participants who would take part in a research study again = **92.9%**

Total responses = 131 Total studies in survey = 23

Part B: Additional contextual prompts for consideration by boards of high performing research active organisations

Impact

1. **Steps are being taken to monitor the local impact of research. Impact may relate to public or patient outcomes and experience, health inequalities, service delivery, economic benefits, and changes in culture, workforce, and knowledge. It can take years for the impact of individual research projects to become clear.**
   - Patient story (Cancer) presented at board in September 2026.
   - Most of our activity is hosted research and therefore we must wait until sponsors issue updates, release results / publications that we are able to share where possible accordingly:
   - 26/27 (Q2) we have had 12 items celebrated in ICON news and 8 study publications.

Priorities

2. **Research reflects the needs of the population served by the organisation, including the priorities in the 5-year population health strategy for the local ICB.**

No of active studies (open & in FU)	182
No. of specialties research active	34
No of active clinicians (PIs / CIs)	60

- The breath of activity across the organisation provides good evidence we are supporting many local priorities / population health needs.
- The NIHR RDN produces ad hoc EDI reports as Trusts do not hold relevant population data to compile the reports / stats. Last one in 2022 showed TSD research had good coverage over the domains. Next data collection due later 26/27. An updated NIHR RDN EDI report for TSD will then be issued.

3. The organisation is seeking to increase the number of patients recruited to interventional research studies, as prioritised in the Life Sciences Sector Plan.

	2025/26 (total)	**2026/27 mid-year**	**Comment**
TSD commercial interventional recruits	38	29	On track to surpass last year's total.
New TSD commercial interventional studies approved	18	8 (currently 5 more in set up)	On track to equal or surpass last year's total.

- These stats show TSD is increasing commercial interventional research activity.

Research maturity

4. The organisation is developing and delivering the core research and development function capacity and capability needed to effectively run research; deliver host site and sponsor responsibilities and support research site maturation and growth. This may involve collaborating with other organisations or providing funding to underpin or kickstart research activity and finding more effective ways of working.

The R&D Department provides comprehensive services to support and facilitate hosting research studies and sponsoring non-CTIMP research; but is not set up or equipped to sponsor CTIMP studies and currently no plans to do this due to little demand to warrant the expense and expertise required.

R&Ds focus over the coming period is strengthening infrastructure, addressing capacity and capability gaps to effectively deliver research, deliver KPIs and to fulfil host and sponsor responsibilities, strengthen regulatory compliances and assurances; while leveraging regional collaborations and cultivating improved sponsor relationships to support the growth and maturity of research activity, especially commercial trials.

TSD are involved with several initiatives with other sites / organisations:

- Part of several industry preferred site partnerships.
- Hub and spoke models, clinical referrals, Patient Identification Centre (PIC) activity, continuing care site (e.g. local child recruits followed up from Bristol Paediatric centre)
- Part of the RDN working Groups
- Leading a regional pilot project assessing software (the ‘Trailling app’) to support referrals to cancer trials initially and hopefully to rollout across all specialties to increase recruitment to trials.
- Leading a regional collaborative pilot looking at a dedicated EPIC / Digital support role to maximise the use of EPIC in clinical trials activity.
- Pump prime funding PIs – RDN funding available.
- Research associateships – RDN funding available.
- Research awards – e.g., NIHR / TMRF research awards, training grants, fellowships etc.

4. The organisation encourages a balance of non-commercial, commercial collaborative and commercial research to meet the population’s needs.

TSD supports a balance portfolio of NIHR commercial: non-commercial studies to maximise all the available funding streams (RDN funding (core, activity, and performance funding), DHSC Research Capability Funding, Trials income.

Ratio	2026/27 mid-year
% Commercial: non-Commercial open studies	29:71
% Commercial: non-commercial recruits	3:97

Commercial

5. In addition to the mandated commercial research reporting domains, the organisation is attracting and facilitating commercial contract research.

- The data above shows we have had steady growth in commercial income over the past 3 years, increasing the number of new commercial studies and currently in set up.
- We work closely with selected industry partners as preferred sites (IQVIA Prime Site, Pfizer, PPD and Novo Nordisk (Cardiology).
- In additional our pipeline of studies and Expression of interest data show a healthy stream of commercial activity.

	25/26 (Q2)	26/27 (Q2)	Comments
No of commercial EOIs received	121	116	Slightly down
No of commercial EOIs positive responses	28 (23%)	35 (30 %)	Showing an improvement

Settings and specialties

6. The organisation supports and enables research activity in wider care settings, including social care and public health research, and across multiple settings.

	2026/27 Q2	Comments
Number of studies open in non-acute settings.	1 (Big Toe – podiatry study)	Reduced compared to 25/26 due to several child health studies undertaken in the community have now transferred over to DPT
Recruitment in non-acute settings.	12 against a target of 7 (Big Toe)	As above
Number of studies in set up in the non-acute setting	0	

- We are actively looking to see how we can improve and set up more community-based research. However, the NIHR portfolio availability of suitable studies is limiting this.

7. There is a balance of research activity across physical and mental health, the social and wider determinants of health, and the life course from early years to end of life.

- TSD research activity is primarily in the acute setting and more limited in community, especially now children's services have transferred to DPT. Mental Health research is undertaken through DPT, social care and local authority and primary care research is managed and flows through the RDN and relevant authorities and not through TSD.

Community engagement:

8. Communities are involved in research priority setting, design, and delivery.

- PPIE activity is primarily involved at the grant and protocol development stage associated with Chief Investigator (CI) studies. TSD has a very small number of CI studies and where appropriate they do consult with and involve relevant patient / carer groups.
- For PI studies local PPIE involvement is generally not possible or appropriate - the portfolio availability determines what we can do alongside organisation and staffing availability and interest which are the primary determinants regarding which studies we undertake.
- The breadth of our portfolio is considerable involving over 25 specialities. We are confident our research covers many of the local health needs and priorities.
- The local RDN have funding and staffing to support regional general PPIE activities.
- Equally there are several national PPIE NIHR initiatives such as the MRES survey. Consequently, we feed into these initiatives as opposed to having separate PPIE activities.

9. Feedback on the outcomes and impact of research is provided to those communities who have contributed.

- This is not routine and more ad hoc as this is the sponsor /CI responsibility to make available relevant publications to participating sites. See Part A Question 4.
- HRA are strengthening guidance to CIs and sponsors regarding transparency and the need to make the results of studies available to sites to pass on to participants.

Collaboration

The organisation works in partnership with other research active organisations to develop capital bids, widen the breadth of care settings in which research is taking place, and build research infrastructure, capacity and capability including with new health and care providers across different settings (including neighbourhood, primary and community care).

a) The organisation supports this to enable maximum system benefits.
b) The organisation is involved in national and international research relevant to the local population.

- TSD primarily undertake studies on the NIHR portfolio which are national and international multi centre studies and the breadth of activity means good coverage across our local population health needs.
- As neighbourhood hubs become established, we will link in with the clinicians and services to see how research can flow though these entities.
- We are exploring how to increase clinical referrals to regional sites to enhance recruitment to studies and enable more studies to be set up and offered in the region.

NIHR research infrastructure

10. The organisation engages effectively with the national and regional NIHR research infrastructure organisations to enable maximum system benefits, including resources, expertise, opportunities, reports, and advice.

- TSD actively works very closely with the NIHR Regional Research Delivery Network (RRDN) teams, including the NIHR Research Support Services (RSS) and NIHR Research Design Services (RDS) as necessary, supporting CIs involved with NIHR grant applications. Equally we get support from the RDN business intelligence teams with regional reports.
- The R&D Director sits on the NIHR regional RDN Partnership Board the NIHR regional Applied Research Centre (ARC) Management Board representing TSD.
- Actively involved with the new tender of NIHR Biomedical Research Centre (BRC) bids with both Exeter and Oxford leading the bids. If successful we will be part of both NIHR BRCs from April 2028.
- We have access to the NIHR Health Tech Network hosted by the University of Exeter and the NIHR Health Determinants Collaborative hosted through the University of Plymouth.

Data-driven research

11. The organisation makes data from clinical source systems available to an NHS Secure Data Environment (SDE) to enable access to demographically representative health data in order to enable high-quality, safe research to benefit patients and the public.

- The Trust supports data to the one Devon Data set, RDN and SW Secure Data Environment (SDE).

12. Researchers have easy, timely and safe access to analysis-ready data, including via NHS SDEs, that enables them to plan and deliver research.

- Researchers can access the SW SDE
- We have established the EPIC one Devon research group to review data requests, if necessary, via EPIC as well as looking at governance arrangements.
- R&D is a member of the newly established Devon Health Data & Research Partnership Group.
- Through these groups we can:
    - Coordinate activity across Devon to reduce duplication and maximise the impact of investment in health data and research.
    - Identify and prioritise opportunities that would benefit from a collaborative approach.
    - TSD is leading the regional pilot of a research digital EPIC post to see how all Trusts can maximise EPIC in supporting clinical trials activity.
    - Develop common approaches to data, infrastructure, and standards where this adds value.
    - Bring together clinical, academic, operational, and technical expertise to accelerate delivery and impact.

- Support the development of a connected Devon-wide data and research ecosystem.

It's early days and looking to shape the group, set priorities and make sure the right people are involved.

13. The organisation is enabled to prioritise the facilitation of nationally prioritised research, if required, for example, in response to pandemics.

- R&D has studies approved and kept in 'sleeper mode' ready to be activated rapidly in response to pandemics as advised by the relevant authorities. e.g. ISARIC study.
- Response to Covid demonstrated our ability to be agile, responsive, and collaborative (e.g. Valena vaccine study – jointly with UHP).

Rare diseases

14. The organisation is taking part in or enabling research into rare diseases. As participant numbers in rare diseases research will be very low, organisations may wish to present the participation number separately from other research participation figures.

a. Data on number of studies in rare disease split commercial and non-commercial *(rare disease study defined by RDN)*

	2023-2024		2024-2025		2025-2026		2026-2027	
	Com	Non-Com	Com	Non-Com	Com	Non-Com	Com	Non-Com
Rare Disease Studies	0	3	0	2	1	3	1	3

b. Recruitment to studies - split C/NC *(rare disease study defined by RDN)*

	2023-2024		2024-2025		2025-2026		2026-2027	
	Com	Non-Com	Com	Non-Com	Com	Non-Com	Com	Non-Com
Number of Recruits into Rare Disease Studies	0	0	0	1	0	4	0	31

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Presented to:	**Trust Board**					
Title of Report	Thirlwall Inquiry Recommendations: Implementation and Assurance Approach					
Date of Meeting	5/11/2026		**Author**	Nicola McMinn, Chief Nurse		
Executive Lead	Chief Nurse		**Executive Sign Off**	Nicola McMinn, Chief Nurse		
Governance Route	Thirlwall Task and Finish Group -> Quality and People Committee and Audit Committee -> Trust Board					
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
	x	x				
Executive Summary	The Thirlwall Inquiry recommendations have implications beyond maternity and neonatal services, including patient safety governance, culture, speaking up, leadership accountability, safeguarding, escalation and organisational learning. A time-limited, Trust-wide Task and Finish Group, led by the Chief Nurse, has been established to coordinate the Trust response. The Group will complete a structured gap analysis, confirm applicability and ownership for each recommendation, identify national timescales and monitor supporting evidence through a central action and assurance tracker. Existing maternity, neonatal and corporate governance arrangements will retain responsibility for delivery, avoiding a parallel improvement programme. QPC and Audit Committee have considered the approach. Trust Board is now asked to endorse the Trust-wide implementation and assurance arrangements. Future oversight will use exception-based reporting and distinguish between action completion, evidence of implementation and evidence of effectiveness. The current position is Moderate Assurance: governance and tracking arrangements are established, but further assurance will develop as the gap analysis is completed and evidence is validated.					
Recommendation	Trust Board is asked to • note the prior consideration by Quality and People Committee and Audit and Risk Committee; • endorse the Trust-wide approach led by the Chief Nurse and the Task and Finish Group as the coordinating mechanism; support delivery through existing governance structures; and • agree that ongoing assurance will be provided through exception-based reporting on recommendations, actions, risks, evidence and national timescales. Closure will require evidence of implementation and, where appropriate, effectiveness.					
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**

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		X	X			X
How this paper supports delivery of the Strategy	The programme supports safer, higher-quality care by strengthening governance, leadership, workforce culture, speaking up, safeguarding, escalation and organisational learning. It provides a clear route from recommendation to accountable delivery, evidence, committee assurance and Board oversight.					
Board Assurance						
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**			
BAF-QS	Quality, Safety, Clinical Outcomes and Patient Experience	12 (3 x 4)	Strengthens the control and assurance framework by providing systematic oversight of Thirlwall-related actions, evidence, risks and escalation through QPC and Audit Committee, with assurance reported to Trust Board.			
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**	
	X				X	
Compliance / Regulatory Requirements	Supports the Trust response to the Thirlwall Inquiry recommendations and alignment with statutory duties for quality, patient safety, safeguarding, speaking up and effective governance. Any subsequent national requirements or deadlines will be incorporated into the action and assurance tracker.					
Ethical or EDI implications?	The programme has important ethical and equality implications, particularly psychological safety, equitable access to speaking-up routes, protection from detriment, inclusive leadership and fair responses to concerns. Delivery leads will consider equality impacts within relevant actions and evidence.					
Assurance rating	Significant	Moderate	Limited	Inadequate		
		X				
Assurance rationale	Moderate Assurance. The Trust has established executive leadership, a multidisciplinary Task and Finish Group and a central action and assurance tracker. QPC and Audit Committee have considered the approach. Controls are generally sound, but the detailed gap analysis, allocation of all actions and validation of implementation and effectiveness evidence are still being completed. Trust Board will receive assurance through established governance arrangements, with material risks or slippage escalated as required.					
Appendices	None					

Torbay and South Devon NHS Foundation Trust

1. **Executive Summary**

The Thirlwall Inquiry recommendations have significant implications for maternity and neonatal services, but also extend across wider organisational responsibilities including culture, speaking up, leadership, escalation of concerns, multidisciplinary working, patient safety intelligence, governance, Board oversight and organisational learning.

A Trust-wide, time-limited Task and Finish Group has therefore been established to ensure that all applicable recommendations are systematically assessed, assigned to the appropriate executive and operational leads, delivered within relevant national timescales and supported by robust evidence of implementation.

This is not intended to create a parallel improvement programme. Maternity and neonatal-specific actions will continue to be delivered through existing specialty governance and improvement arrangements. The Task and Finish Group provides the overarching mechanism to identify cross-Trust implications, coordinate ownership and give QPC confidence that no recommendation is overlooked.

The first Task and Finish Group - Thirlwall Recommendations took place on 14 October 2026, chaired by the Chief Nurse, with multidisciplinary representation. A central TSDFT Thirlwall Action Assurance Tracker has been developed to support executive ownership, delivery monitoring and evidence-based closure.

Current assurance: QPC and Audit Committee have considered the proposed governance and oversight mechanism. There is reasonable assurance that appropriate arrangements are being established. Full assurance on implementation and effectiveness cannot yet be given while the detailed gap analysis, allocation of ownership and evidence validation are being completed.

2. Proposed Approach

The Task and Finish Group will oversee a structured assessment of the Thirlwall recommendations through a Trust-wide lens, distinguishing between:

This assessment will distinguish between recommendations specific to maternity and neonatal services, those requiring wider organisational action, and those whose implications or delivery arrangements remain dependent on further national direction.

For each applicable recommendation, the Trust will confirm its baseline position and applicability, identify named executive and operational ownership, and map any existing work or governance already contributing to delivery. Any remaining gaps will be translated into clear actions, aligned to national deadlines or milestones where these are specified. The required evidence of implementation and effectiveness will be agreed from the outset, alongside a RAG assurance position and clear escalation arrangements.

The Trust's existing tracker already provides for national deadlines, proposed executive/SRO ownership, milestones, required outcomes, compliance evidence, effectiveness evidence, assurance routes, reporting committees and dependencies/risks.

3. **Governance and Membership**

The Task and Finish Group is chaired by the Chief Nurse and has been established with multidisciplinary representation.

Existing maternity and neonatal governance will remain responsible for delivering recommendations that sit within that specialty. This avoids duplication with established improvement arrangements, while ensuring that wider organisational recommendations have appropriate ownership and oversight.

The Task and Finish Group's role is therefore to coordinate, challenge and assure, rather than take operational ownership away from existing governance structures.

4. **Assurance and Oversight**

QPC and Audit Committee have considered the approach. It is proposed that future oversight uses regular exception-based assurance, rather than detailed reporting of every individual action.

Reporting will provide a concise view of the overall delivery and RAG position, progress against national timescales and any recommendations where ownership or delivery remains unresolved. It will highlight overdue actions, gaps in evidence of implementation, emerging evidence of effectiveness and sustainability, and any significant dependencies or risks requiring executive or QPC escalation.

The overarching governance principle is:

The Task and Finish Group coordinates and scrutinises; existing governance structures deliver; QPC provides quality and people assurance and challenge; Audit Committee considers the effectiveness of the overall control and assurance framework; and Trust Board receives strategic oversight and assurance through established governance arrangements.

5. **Next Steps**

The immediate priority is to complete the Trust-wide gap analysis, confirm the applicability and ownership of each recommendation, and map existing maternity, neonatal and wider Trust activity against the required outcomes. This will identify where additional action is needed, clarify relevant national milestones and deadlines, and establish the evidence required to demonstrate both implementation and effectiveness. Regular exception reporting will then be established through QPC and Audit Committee, with assurance and material delivery risks escalated to Trust Board through existing Trust risk and governance arrangements.

The intention is for the Task and Finish Group to remain time limited, with delivery and ongoing assurance progressively embedded within existing business-as-usual governance.

6. **Recommendation**

Trust Board is asked to:

NOTE that QPC and Audit Committee have considered the Trust-wide approach being led by the Chief Nurse;

ENDORSE the Task and Finish Group as the coordinating mechanism for the Trust’s response;

Torbay and South Devon NHS Foundation Trust

SUPPORT the principle that existing governance structures remain accountable for delivery, avoiding parallel workstreams;

AGREE that ongoing assurance will be provided through regular exception-based reporting on progress, risks, evidence and relevant national timescales, with material matters escalated to Trust Board; and

NOTE that future assurance will focus not only on completion of actions but on evidence of implementation and effectiveness.

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Presented to:	**Trust Board**					
Title of Report	Committee Chairs' Report					
Date of Meeting	5th November 2026		**Author**	Sarah Fox Corporate Governance Mangaer		
Executive Lead	Cath Parnell, Associate Director Corporate Governance & Trust Secretary		**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 – Audit and Risk Committee Chair's Report Appendix 2 - Finance and Operations Committee Chair's Report Appendix 3 – Quality and Assurance Committee Chair's Report

Committee Chairs' Report - Audit and Risk Committee – 29 October 2026

REPORTS RECEIVED BY COMMITTEE:

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

- Counter Fraud Interim Report
- ASW Assurance Interim report
- ASW Assurance Annual Report
- Board Assurance Framework – Limited Assurance
- Information Governance Update – Moderate Assurance
- SIRO Annual Report – Moderate Assurance
- Thirlwall Inquiry Recommendations – Moderate Assurance
- Data Quality Audit Proposal
- Corporate Documents Progress Update – Limited Assurance
- EPIC EPR Asset: Proposed IAS 36 Impairment Review and Accounting Approach
- Cybersecurity Assurance Update – Limited Assurance
- Waiver of Competition Report – Limited Assurance
- Losses and Special Payments – 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 rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	TSD continues to experience a backlog of SAR/FOI requests, primarily due to increasing volumes and staff shortages. The ICO has issued a notice concerning the Trust's plans to address the SAR backlog, and a full response has been provided. A new Disclosure Officer starts in November and is expected to help reduce the backlog. Further information on the potential consequences of the backlog is to be provided.

	Whilst assurance on Cyber remains Limited, progress in areas like the data centre maintain positive momentum towards improving assurance.
ADVISE:	Counter Fraud needs to liaise with Simon Tapley on the transfer of ASC next year, particularly in relation to existing and any new fraud investigations. This liaison is essential given the complexity of aspects of the service and the potential fraud risks identified.
ASSURE:	The Committee discussed the Trust's initial response and plans to address the recommendations arising from the Thirlwall Inquiry and agreed that methodologies and processes were appropriate, taking comfort from the preceding discussion of this issue at QPC. The Committee thanked all those involved for delivering the response promptly.
RISK:	The move to the new accounting system has been delayed until 2027/28. As a result, certain older outstanding external audit recommendations will remain unresolved for longer than previously anticipated. A report was requested to reassess the resulting risk and identify any further actions required. A focused Internal Audit of Data Quality has been agreed, covering the key external reporting measures for UEC, RTT and cancer. The discussion also highlighted a broader need for further investment in BI. Potential fraud at other trusts involving payments to employees for unworked shifts was highlighted and discussed. A new e-rota system may help mitigate this risk, although implementation at TSD has been further delayed. Such fraud also occurs in trusts with e-rota systems already in place. ASW/CF will consider this issue further. The issue also relates to the wider work programme being discussed at QPC and reinforces the need for improved productivity measures and monitoring.
CELEBRATE OUTSTANDING:	Good progress continues to be made on the Risk/BAF frameworks, with assurance rating planned to move to Moderate by next ARC meeting. Given the emerging maturity

	of this system, the board should consider revisiting the Risk Appetites previously discussed as it was felt that some of these may need refinement. Progress continues on updating corporate documents, although at a slower pace than previously advised. Further refinements to reporting were agreed to maintain a focus on key areas. The new section on the website relating to the FOI disclosure log will start to assist in dealing with FOI enquiries. Members should be encouraged to read some of these to gain a perspective ion the request made. I particularly liked the (rather circular) FOI request requesting the number of FOI requests made by a certain organisation.

Committee Chairs' Report – 28 October 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: • **Board Assurance Framework and Corporate Risk Register: Quarter 2 Progress Summary (July–September 2026)** – LIMITED assurance • **Operational Performance Report** – LIMITED assurance • **Trauma and Orthopaedic Transformation Programme Plan** – LIMITED assurance • **Internal Audit Reports – Financial Management (CIP) and Waiver of Competition** – MODERATE assurance • **Monthly Finance Report** – MODERATE assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce • **SBS Go Live Update** – MODERATE assurance • **Capital Spend and Planning – 2026/27 to 2030/31** – LIMITED assurance • **2027/28 Business Planning Update** – MODERATE assurance • **Gadeon House Histopathology Capital Project Update** – MODERATE assurance • **Digital Update** – LIMITED 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 [INADEQUATE - LIMITED – MODERATE – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	- Trauma & Orthopaedics. Diagnostic report finalised and issued to clinical teams for engagement and response. T&O continues to operate at a loss, with high benchmarked costs, and a high waiting list, yet there are significant productivity and performance opportunities identified in diagnostic completed Jul 26. Recovery plan identified (2 phases): o Phase 1. Admissions & scheduling / Fracture clinic / Trauma pathway

	○ Phase 2. Elective pathway / Theatre efficiency / Carpel tunnel service Intent for recovery phases to be delivered across Q3/Q4. - SBS Go-Live. Reset to 1 Apr 27 (from initial date 1 Apr 26); 1 Dec 26 represented unacceptable delivery and financial reporting risk. Issues included: ○ Data quality ○ Local IT teams' readiness ○ EPIC & other 3rd Party interfaces ○ End-user testing and cut-over plans
ADVISE:	- BAF/CRR. Strategic risk profile remains static at HY point with scores unchanged and all above appetite. - 27/28 Business Planning. Deeper analysis and planning activity taking place across Care Groups with cross-cutting risks to planning process being identified. Trust has formally written to ICB seeking early discussion on matters arising (ULP, and contractual). Trust has also formally responded to draft commissioning intentions which include focus on: neighbourhood health, prevention, proactive care, and care closer to home, alongside clinically sustainable specialist services. A Board Assurance Statement assessing the maturity of Trust planning will be required idc. - Digital. Digital resilience continues to improve through datacentre migration, MS Sentinel integration, and CIS Level 2 compliance for 80% mission-critical servers. Unsupported systems present continuing management issue, while, additionally, several cyber workstreams are on hold pending resource. Two pilot projects have been launched: ○ AVT. Trust is part of pilot for AVT; mobilisation starts Nov 26 with go-live by end Mar 27 for 3 outpatient specialities (yet tbd). ○ Copilot. Project progressing to identify use cases, IG controls, and to measure productivity benefits.
ASSURE:	- Operations ○ UEC. Signs of improvement showing traction made after triage / pathway plans implemented. SDEC opened on schedule.

	○ RTT. Recent trajectories meeting target; long waiters remain a concern (especially Ophthalmology and Orthopaedics). ○ Cancer. 28-day faster diagnostics below trajectory (especially Dermatology) as is 62-day performance. ○ Diagnostics. DM01 continues to be a challenge, but currently on plan. ○ Ambulance H/Os. 5.5% increase in volume Sep 25 to Sep 26, but timing improved across Q2 to 39mins. ○ National Benchmarking. Benchmarking improved across the board except for two metrics that remained unchanged. - Internal Audits: ○ CIP. Governance established iaw CIP Handbook; risk to delivery identified. ○ Waivers. Justifications inconsistent, and occasionally retrospective with evidence for waivers requiring strengthening. - M6 Finance. Trust is on plan at HY point; EOY forecast remains to deliver breakeven budget (with DSF support) and has been reported to NHSE. ○ Delivery risk is £6.4m baseline (CIP delivery & ASC/CHC cost pressures), with £2.8m risk to ULP; ULP risk to be reviewed at M8. ○ Cash is below plan (late TC payment & non-drawdown of planned PDC support); intent is to now apply for £10m PDC and repay by M12. ○ Recovery actions to maintain breakeven forecast include: ▪ Vacancy freeze ▪ Bank & Agency reductions ▪ Further productivity gains ▪ Commercial income increases - Capital. Programme continues broadly on track, is not without risk, yet forecasting to spend allocated CDEL in full. ○ Gadeon House. RIBA Stage 3 complete. Cost assurance assessment currently c£7.3m with £3.7m affordability gap. £1m additional system funding reduces gap, with further reduction anticipated via value engineering at RIBA Stage 4.
RISK:	- Digital TOM. Lack of delivery of system-wide Digital TOM having material

	impact on strategy delivery. This issue has been previously escalated to Board for System resolution without success. - Fragility of breakeven delivery noting our ambition. Of note: o Trust-wide reduction of 199 WTE (c£3.7m) between M7 – M12. o Sickness cost
CELEBRATE OUTSTANDING:	- ED and Clinical Teams engaged in establishment of new triage approach, SDEC and new acute pathways. - Estates and Clinical Teams engaged in Tower risk reduction and bed/ward relocations.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Finance and Operations Committee**			
Title of Report	Operational Performance Report			
Date of Meeting	**28 October 2026**	**Author**	Chief Operating Officer	
Executive Lead	**Chief Operating Officer**	**Executive Sign Off**		
Governance Route				
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		Yes		
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** • Performance improvement across all key measures in September with further improvement in first half of October • Reductions in corridor care evidenced in September and continued into October • Overall demand increases across Type 1, Type 3 and ambulance handover • New UEC improvement plan in place and showing traction in delivery • New SDEC area opened in October with plans in development for expansion **Elective Performance Referral To Treatment (RTT)** • RTT waiting list growth remains broadly within the levels anticipated through Epic go-live modelling however there has been a significant drop in performance from April. Analysis into the significant drop in performance has been concluded with changes identified in the counting of RTT pathways from legacy system, data quality and go-live activity reductions with slower than planned recovery. • Current RTT performance has now started to improve with September trajectory met and forecasting to meet October trajectory at present • Long waiters remain a concern, particularly in Ophthalmology and Orthopaedics. Plan requested for non-admitted clearance by end of November.			

Torbay and South Devon NHS Foundation Trust

	Cancer • 28-day Faster Diagnosis Standard performance worsened in month, driven by decline in dermatology is behind trajectory. Plan in place but is awaiting modelling of impact • 62-day cancer performance also worsened in month but improvements forecasted in October **Diagnostics** • Diagnostic performance (DM01) remained a challenge throughout FY25/26, and this has continued into FY26/27. The August national reported position of patients waiting over 6 weeks for diagnostics is 21.3% which is ahead of trajectory. This is a continued improved position from April (39.4%). • 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		

How this paper supports delivery of the Strategy	Ensures timely access to services that are safe and provide good patient experience.

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	

Compliance / Regulatory Requirements				
Ethical or EDI implications?				
Assurance rating	Significant	Moderate	Limited	Inadequate
Assurance rationale				
Appendices				

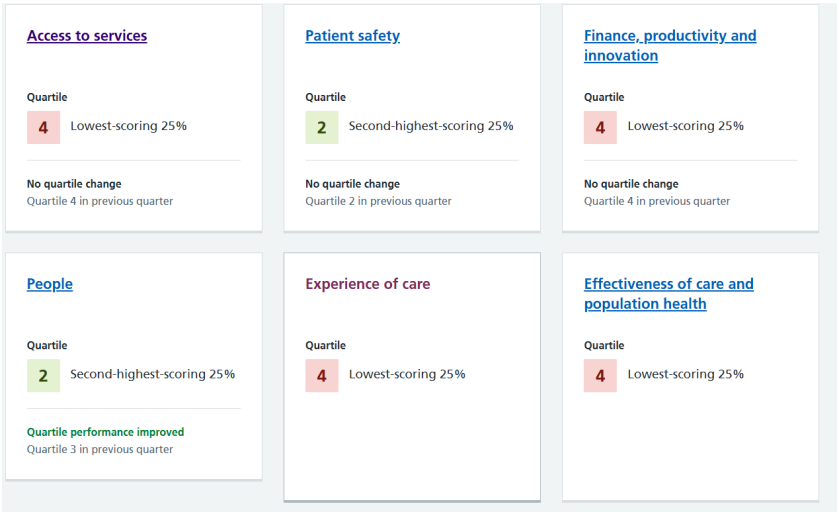
Torbay and South Devon NHS Foundation Trust

Operational Performance Report

Introduction and background

1. This report provides a consolidated update on key operational performance issues and measures to provide the necessary assurance to the Committee in respect of the key performance indicators measured as part of the 2026/2027 Operating Plan. This report continues to report on the key areas of performance that are measured nationally as part of the 2026/2027 operating plan, the performance oversight processes led by NHSE South-West, and the contract oversight processes overseen by NHS Devon ICB.

2. Under the NHS Oversight Framework the Trust is currently in Segment 3 for Q1 2026/27; with an average score of 2.67 and ranked 101 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 movement of one ranking place from the previous quarterly assessment where the Trust was ranked at 102. 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.



3. The next Quarterly update being Q2 2026/27 segmentation will be available in November 2026.

4. As part of the national sign off for the 'go live' of the new electronic patient record system that went live on the 3rd April 2026, the national team had mandated that elective waiting times performance will not be reported by the Trust for the months of April, May and June (Q1). Extension to end of October since agreed following deep dive into data quality and changes in reporting methodology from legacy systems. Oversight Framework assessment for Q2 will continue to use the Trust numbers from our weekly submission on the 29th March 2026 with the Trust recommencing national reporting in November.

Torbay and South Devon NHS Foundation Trust

Purpose of report

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

National Benchmarking

6. The table below reflects latest published data (as at 12/10/26) 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 117 Trusts) against the previous reporting month.

Provider	Elective proportion waiting within 18 weeks ▲ Rank out of 117 Aug 2026	Elective proportion waiting over 52 weeks Rank out of 117 Aug 2026	Cancer faster diagnosis Rank out of 117 Aug 2026	Cancer 31-day treatment Rank out of 117 Aug 2026	Cancer 62-day combined Rank out of 117 Aug 2026	Diagnostics proportion waiting over 6 weeks Rank out of 117 Aug 2026	A&E 4-hour performance Rank out of 117 Sep 2026	A&E 12-hour performance Rank out of 117 Sep 2026
Torbay And South Devon NHS Foundation Trust	**66.4%** 44	1.8% 81	60.6% 116	94.9% 60	70.0% 76	22.2% 68	71.5% 77	12.2% 75

Metric	Previous available rank	Latest available rank	Improved/ Worsened
**RTT 18-week wait	46 (July 2026)	44 (Aug 2026)	Improved
**RTT 52-week wait	81 (July 2026)	81 (Aug 2026)	No Change
Cancer FDS	116 (July 2026)	116 (Aug 2026)	No Change
Cancer 31-day wait	75 (July 2026)	60 (Aug 2026)	Improved
Cancer 62-day wait	110 (July 2026)	76 (Aug 2026)	Improved
Diagnostic wait over 6wks	78 (July 2026)	68 (Aug 2026)	Improved
UEC – 4-hour wait	111 (August 2026)	77 (Sept 2026)	Improved
UEC 12-hour wait	91 (August 2026	75 (Sept 2026)	Improved

** based on March 2026 performance due to reporting freeze

Torbay and South Devon NHS Foundation Trust

Urgent and Emergency Care

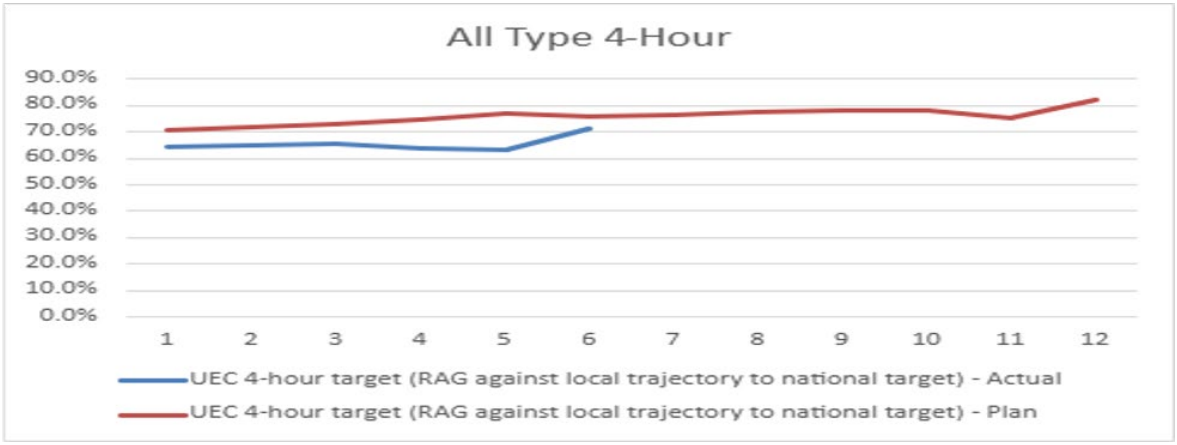
Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position	Forecast End of Quarter 2 Position	Forecast Improvement or Worsening
Percentage of emergency department attendances admitted, transferred or discharged within four hours score	3.85 Q1 2026/27	Q1 64.8%	71.4% (September)	~79%	Improving
Percentage of emergency department attendances spending over 12 hours in the department score	2.76 Q1 2026/27	Q1 10.9%	12.9% (September)	10% (avg Q2)	Improving

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS — Torbay and South Devon NHS

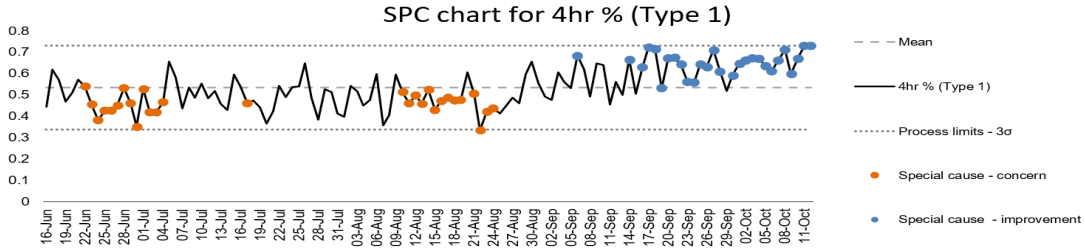
Data RAG rated against monthly Operational Plan trajectory **Bold number = national data**	Target March 2027	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Urgent and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)			1823	810	624	559	1283	621	755	953	1394	1365	1338	1612	1020
Ambulance handovers - time lost over 15 mins - Plan										641	676	623	681	674	662
Average handover time (mins) - Actual			60	33	29	27	45	30	31	38	47	49	47	55	39
Average handover time (mins) - Plan	30 mins		38	42	42	45	42	41	37	30	30	30	30	30	30
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Actual	0		655	585	549	520	918	740	734	676	839	805	950	1001	904
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan										394	655	469	423	394	606
Percentage of patients waiting over 12 hours in ED - Actual	7.7%		**9.7%**	**8.5%**	**8.3%**	**7.5%**	**13.6%**	**12.1%**	**10.6%**	**9.8%**	**11.7%**	**11.1%**	**12.9%**	**13.5%**	**12.2%**
Percentage of patients waiting over 12 hours in ED - Plan			8.2%	9.9%	8.4%	7.2%	7.0%	7.0%	6.1%	5.4%	8.3%	6.2%	5.2%	4.9%	8.5%
UEC 4-hour target (RAG against local trajectory to national target) - Actual	82%		**68.3%**	**68.0%**	**68.3%**	**70.8%**	**67.9%**	**66.4%**	**66.6%**	**64.2%**	**64.7%**	**65.3%**	**63.9%**	**63.4%**	71.4%
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%	77.0%	76.0%
% patient discharges pre-noon - Actual			21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%	13.6%	12.5%
% 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			8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%	18.0%	18.4%
Percentage of inpatients with No Criteria to Reside (acute) - Plan	<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

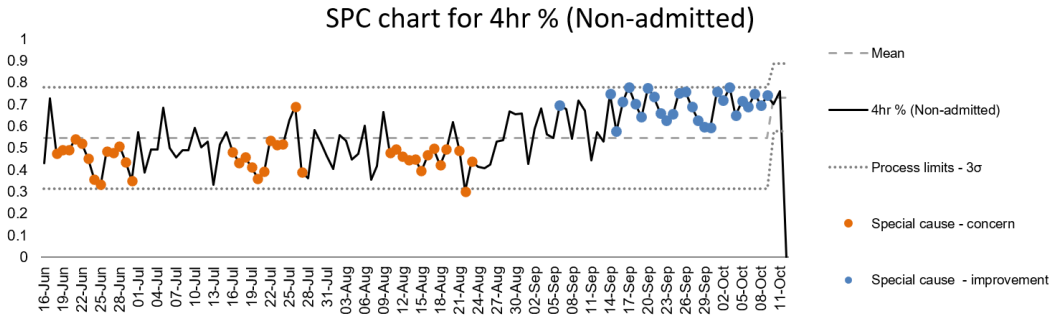
4-hour and 12-Hour Performance

7. The Trust did not achieve the operational plan trajectory of 76% for 4-hour performance with performance for September 2026 at 71.4%.



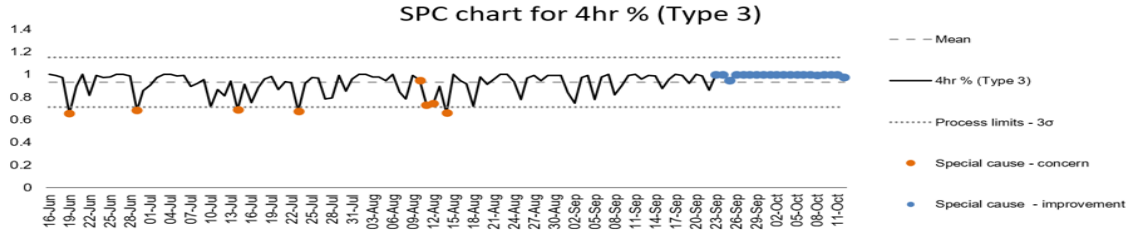
8. The September position represents a significant improvement from August (63.4%) and demonstrates the impact of the actions being taken in line with UEC improvement plan that was shared in the September board and committee reports. Further improvements are forecast in October and as of the 14th October, performance was on target to exceed the nationally submitted October trajectory. In September, there has been a major focus on non-admitted pathways to implement faster assessment and onward specialist review, including improved streaming to alternative services. The non-admitted pathway improvement can be demonstrated in the charts below that show the impact on Type 1 performance and the impact on non-admitted ED performance.





9. Improvements have also been delivered in Type 3 performance following the implementation of the new booked appointments system at Newton Abbott UTC.

This plan has been implemented as a response to the 12.5% demand growth experienced at the UTC so far this year and has supported patients to receive their care and treatment in a more scheduled way with positive impacts described by both staff and patients within the service. Since the implementation of this model, performance has returned to near 100%.



10. In September 2026, the Integrated Care Organisation (ICO) managed 11,126 all type UEC attendances. The Emergency Department recorded 7,383 type 1 attendances which is a 4.5% increase in activity from September 2026 and was the 4th busiest month on record.

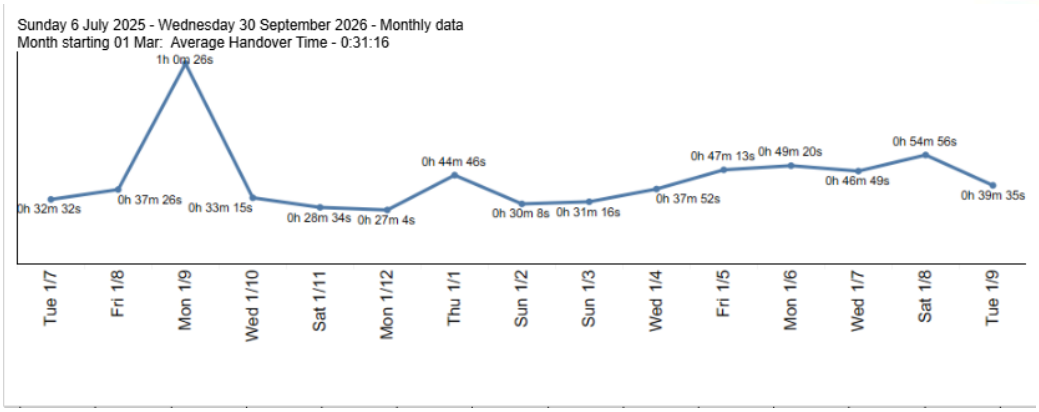
11. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department improved to 12.2% (from 12.9% in August) of total attendances. The plan to date to focus on the non-admitted cohort of patients has significantly reduced the average total time spent in the emergency department, however it is still recognised that long wait times for admitted patients would continue. To address this, the new Unscheduled Care Village will commence operation on the 15th October which will provide a new medical same day emergency care service for medical patients who could receive their treatment and return home on the same day, rather than requiring admission.

12. Alongside this, specialties across all three care groups are creating plans to adhere to internal professional standards and develop alternative pathways for speciality accepted patients to eliminate long waits in the emergency department and enable patients to receive timely care. It is expected that these plans will be initiated in November and will contribute to the Trust winter plan.

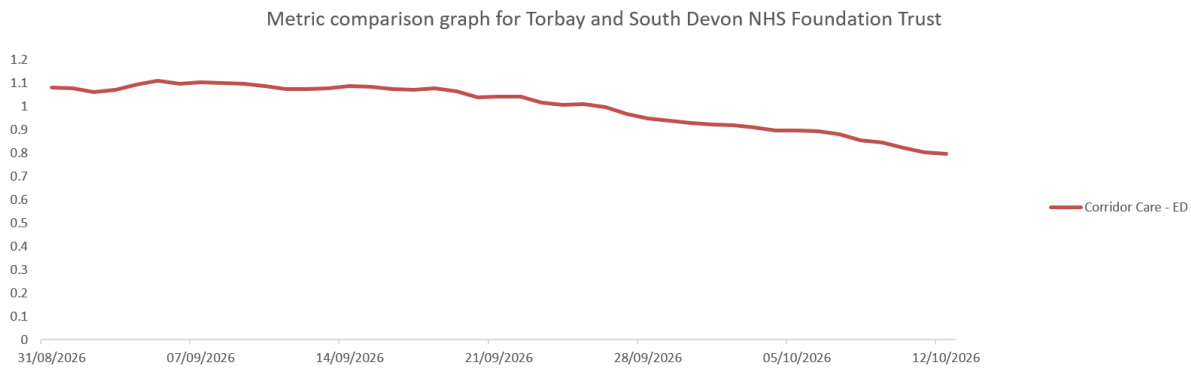
Ambulance Handover Delays

13. The total number of ambulance conveyances to the Trust in September 2026 was 2478, a 5.5% increase on handovers from September 2025.

14. The Trust ambulance handover position improved to 39 minutes from 56 minutes in August. There was a further reduction in the number of handover delays reported > 45 minutes to 548 from 887 reported in August. The improvement has continued into October with further reductions in ambulance handover times recorded to date.



15. One of the key quality and performance aims for the Trust this year remains the elimination of corridor care. While significant amounts of work are still required to enable and sustain this objective, improvement has been demonstrated as a result of the actions undertaken to date.



16. While performance improvement has been demonstrated and has continued into October, it is recognised that the improvement programme is still in progress and issues such as demand and winter pressures have the potential to impact on progress. Due to this the Committee is asked to agree that assurance is **limited** against delivery of all of the UEC performance targets, however it is recommended that **Satisfactory** assurance can be taken on the plans in place to enable the required improvement.

Elective Care – RTT

17. The latest position covering period Q1 2026/27 has been published 14/09/26. Due to the agreement to not use RTT monthly data due to EPIC go live, an up to date position for Q1 has not been applied to the Oversight Framework. The table below shows our Q4 score and data, with updated current position (September and Q2) forecast for comparison. It is expected for the current RTT reporting holiday to continue until the end of October. The Trust continues to monitor its up to date position internally.

Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position (September)	End of Quarter 2 Position	Forecast NOF score - Improvement or Worsening
Percentage of patients waiting over 52 weeks for elective treatment score	3.03 Q4 2025/26	1.8%	3.8%	3.8% (latest month Q2)	Worsening ** against Q4
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score	2.16 Q4 2025/26	66.4%	58.5%	58.5% (latest month Q2)	Worsening ** against Q4

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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Elective Care															
RTT 78 week wait incomplete pathway - Actual			13	16	9	9	13	8	7	9	9	11	11	19	22
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			110	109	84	94	83	76	47	76	135	169	182	169	174
RTT 65 week wait incomplete pathway - Plan	0		43	23	3	0	0	0	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	647	607	663	604	607	600	799	993	1088	1317	1249	1209
RTT 52 week wait incomplete pathway - Plan	292		673	586	505	449	383	327	268	805	941	1088	1009	929	850
RTT % Incomplete pathways <18 wks - Actual			**70.4%**	**69.3%**	**68.7%**	**67.5%**	**67.0%**	**66.8%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	56.8%	58.5%
RTT % Incomplete pathways <18 wks - Plan	73.8%		64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%	57.0%	59.0%	61.0%	62.0%
RTT Wait for first appointment <18 weeks - Actual			73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	62.4%	62.6%	60.7%	62.9%
RTT Wait for first appointment <18 weeks - Plan	74.0%		67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%	67.4%	66.8%	68.0%
Cancer: 28-day FDS - Actual			**67.3%**	**75.7%**	**76.2%**	**78.3%**	**60.6%**	**79.7%**	**75.7%**	**48.0%**	**45.5%**	**57.1%**	**58.5%**	57.9%	60.3%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%	57.4%	73.0%	77.0%	82.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			**63.2%**	**70.4%**	**71.1%**	**79.8%**	**75.2%**	**67.1%**	**60.1%**	**58.5%**	**48.9%**	**53.6%**	**57.9%**	69.3%	64.7%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%	78.8%	79.2%	79.9%	79.5%
Cancer: No of patients waiting >62 days to start treatment - Actual			176	132	91	119	159	214	201	276	288	347	272	276	262
Cancer: No of patients waiting >62 days to start treatment - Plan															
Cancer: % of patients > 62 days to start treatment - Actual			7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	12.0%	8.9%	9.5%	7.6%
Cancer: % of patients > 62 days to start treatment - Plan															
Diagnostics - proportion waiting over 6 weeks - Actual			**36.8%**	**29.4%**	**28.4%**	**30.4%**	**35.8%**	**30.6%**	**37.4%**	**39.4%**	**34.6%**	**25.4%**	**23.1%**	23.7%	24.1%
Diagnostics - proportion waiting over 6 weeks - Plan	14.9%			5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%	29.2%	27.7%	25.6%	23.9%	21.4%

RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

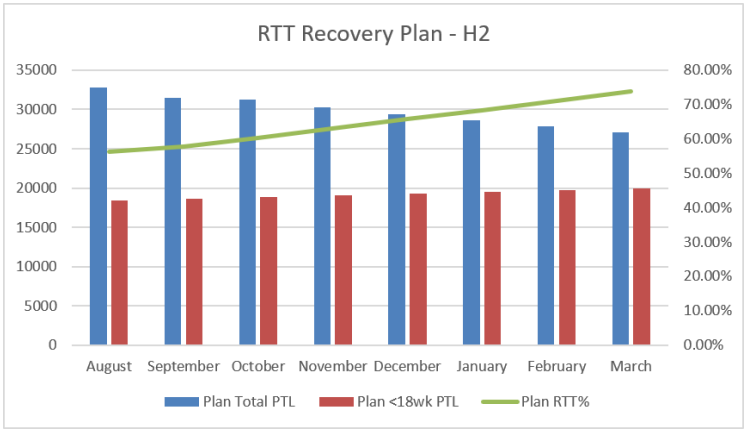
18. The table above represents the most recent month's Trust level data and is not the final nationally reported position due to the delayed publication of national data in September 2026.

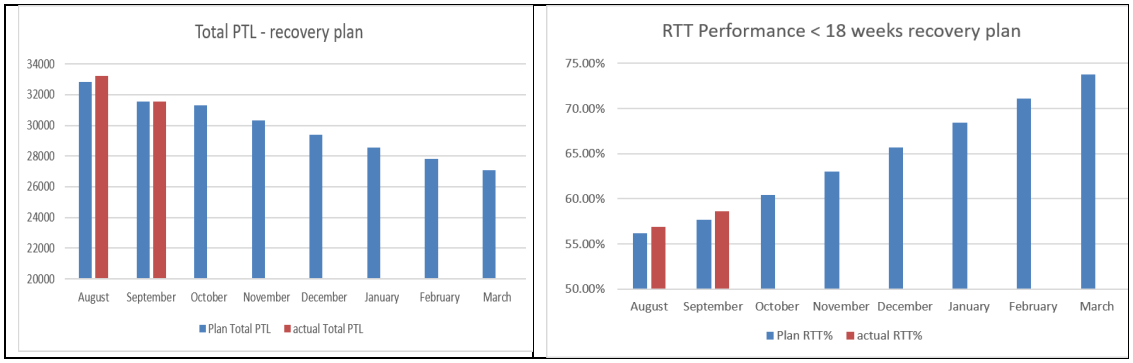
19. At present the Trust remains ahead of waiting list forecast with the RTT waiting list currently at 31,775 for September, however, RTT performance for September is below original operational plan (62%) at 58.52%, this being ahead of revised recovery plan submitted in August (57.7%). Teams continue delivering on recovery plans as previously described in the September reports including providing additional activity and improving productivity within specialities. Work has been ongoing with speciality clinical leads to identify productivity opportunities which have now been implemented across numerous specialties aimed at increasing volumes of first outpatient appointments and additional patients on operating lists..

20. The Trust continues to commit to returning performance recovery to operational plan target of 73.8% in March 2027 and has met its recovery trajectory in September (57.7%). To achieve the March position the RTT incomplete waiting

list will need reduce further to around 27,000 active pathways. This is a considerable challenge and will require full delivery of productivity opportunities and clinic utilisation along with targeted funding for additional activity above core capacity.

RTT recovery trajectory and progress to end September





21. Reduction of long waits over 52 weeks to 1% of incomplete pathways remains the target to achieve by end of March however at present, minimal progress is being made against this standard. This cohort does include patients for surgery with orthopaedic procedures being a significant challenge, however, also includes patients on non-admitted pathways that will be targeted through the focus on outpatient productivity and targeted capacity improvements. The end of September position and split between non admitted and admitted pathways is shown in table below. A significant proportion of the current 52-week position remains patients on non-admitted pathway and an internal target has been set to have plans in place for each of these patients by the end of November, including those that would breach this standard by that point.

Table of 52 weeks by admitted / non admitted by Treatment Function

Treatment Function	Admitted	non admitted	Grand Total
Cardiology		8	8
Clinical Neurophysiology		1	1
Colorectal Surgery	10	7	17
Dermatology		1	1
Endocrinology		20	20
Ent	15	99	114
Geriatric Medicine		3	3
Gynaecology	80	7	87
Interventional Radiology	1		1
Neurology		1	1
Ophthalmology	92	297	389
Oral Surgery	64	36	100
Orthodontics	1	4	5
Paediatric Trauma And Orthopaedics		20	20
Paediatrics		1	1
Pain Management	4	43	47
Physiotherapy		2	2
Rheumatology		1	1
Trauma &Orthopaedics	180	105	285
Upper Gastrointestinal Surgery	25	9	34
Urology	9	17	26
Vascular Surgery	3		3
Grand Total	484	682	1166

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

Cancer and Diagnostics

Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position	Q2 forecast	Forecast Improvement or Worsening
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score	3.95 Q1 2026/27 Rank115	51.1%	56% (Sept 2026)	60.5% (avg Q2)	Static
Percentage of patients treated for cancer within 62 days of referral score	3.90 Q1 2026/27 Rank113	53.4%	64.7% (Sept 2026)	64.6% (avg Q2)	Static

Cancer Waiting Times Standards

23. The table below demonstrates the monthly performance across the cancer waiting times standards from May to September; the 28-day FDS, 31-day decision to treatment, and 62-day referral to treatment standards. We saw an improvement from May to August, but capacity challenges in Dermatology have been the main driver in the September decline.

	May 2026	June 2026	July 2026	August 2026	September 2026
28-day Faster Diagnosis Standard	45.5%	57.1%	58.4%	60.6%	56% (Forecast)
31-day treatment	92.8%	93%	93%	94.7%	95% (forecast)
62-day cancer RTT	48.9%	54%	57.6%	70.0%	65% (forecast)
62-day backlog	288 (8.6%)	347 (12.0%)	300 (8.7%)	287 (9.7%)	264 (8.9%)

August 2026 forecast

24. Faster Diagnosis Standard (FDS): In September, the current position is 56%. We have seen recovery in many specialties, notably Breast and Gynaecology although they still remain below plan.

FDS Performance	August	September
Breast	74%	82% ↑
Gynaecology	47%	55% ↑
Skin	55%	37% ↓

25. 62-day Cancer Referral to Treatment: We finished August at after a positive run of performance at 70% but see a downturn in September, currently forecast at 65%. Behind this the Backlog has continued to improve, but a significant proportion remains within Skin.

Actions and proposed impact

- Skin: In-house Photohub clinics began on 23 September, with expansion planned through October to support tele-dermatology triage and prioritisation of higher-risk lesions. Additional insourcing is planned from October and a locum extension provides additional capacity. Reprioritisation of recovery funding is allowing more capacity to be procured.

- Gynaecology: Peninsula Cancer Alliance has awarded £65,000 to support cancer pathway recovery. This will allow for approximately 200 additional ultrasound scans and 100 hysteroscopy procedures, aimed at reducing the diagnostic backlog and improving Faster Diagnosis Standard performance.

- Breast: Waiting times have improved through September, with additional GP sessions, timetable optimisation, expanded nurse-led clinics and increased radiology capacity. Appointments are now being booked within two weeks.

26. The Trust cancer cabinet recommenced in October and will instigate a programme of reviewing all tumour site pathways to assess adherence to

national best practice pathways in terms of direct to test, one stop capacity and timed pathway compliance.

Diagnostic waiting times

27. Diagnostic performance (DM01) remained a challenge throughout FY25/26, and this has continued into FY26/27. The September national reported position of patients waiting over 6 weeks for diagnostics is 21.3% which is on trajectory of 21.4%. This is continued improved position from April (39.4%). The latest position is shown below:

Month end performance

Test	6+ weeks	Total	Performance %	
Audiology - Audiology Assessments	11	485	2.3%	Improvement
Cardiology - echocardiography	68	368	18.5%	Deterioration
Colonoscopy	65	345	18.8%	Improvement
Computed Tomography	23	876	3.2%	Improvement
Cystoscopy	40	132	30.3%	Deterioration
Dexa Scan	354	551	64.2%	Deterioration
Flexi sigmoidoscopy	6	66	9.1%	Improvement
Gastroscopy	30	313	9.6%	Improvement
Magnetic Resonance Imaging	221	1208	18.3%	No change
Neurophysiology - peripheral neurophysiology	35	108	32.4%	Deterioration
Non-obstetric ultrasound	625	2485	25.2%	Improvement
Respiratory physiology - sleep studies	0	41	0.0%	Improvement
Urodynamics - pressures & flow	4	50	8.0%	Improvement
Total	**1495**	**7020**	**21.3%**	

Operational update

Modality	Sept %	August %	Operational update
Audiology	2.3%	5.1%	Audiology validation has completed and is showing a positive position. This will continue to be monitored via clinical validation. There remains an active Epic ticket into the paediatric hearing clinic appointments with no solution as yet, manual validation will continue until this can be resolved.
Cardiology	18.5%	11.4%	Data quality issues have still not been fully rectified despite numerous discussions and ongoing escalation through a variety of forums and meetings over an extended period. This has remained a key area of concern. There was a further deterioration in performance and data quality during the summer

			months, which was largely attributable to annual leave and reduced staffing capacity across the service. However, those pressures have now eased, and the service would expect to see a gradual improvement in both data quality and overall performance over the coming weeks as teams return to full capacity and focus on addressing the outstanding issues.
CT	3.2%	3.7%	No concerns with CT delivering DM01.
Cystoscopy	30.3%	24.7%	A replacement locum commenced on 14 September 2026 and will support with recovery of the position – the position is forecast to recover in October 2026
DEXA	64.2%	58.3%	Funding is now agreed for additional Dexa activity which will be provided by a UHP mobile service. It has been agreed that they will provide an additional 60 slots per month. The anticipated plan is to see 120 patients before Christmas, but this depends on the 4-week lead time and availability at short notice. A revised trajectory will be developed.
Flexible sigmoidoscopy	9.1%	14.7%	For Colonoscopy, Flexi-Sigmoidoscopy and Gastroscopy the deterioration in performance is solely related to reductions for Epic implementation, where activity was reduced to 50%. The service anticipated that the performance would deteriorate further before seeing an improvement owing to 6+ week breaches related to the reduction in activity for Epic. The position continues to recover for Flexi and Gastroscopy but Colonoscopy remains under pressure from higher than average USC referrals. This gives Endoscopy a mean percentage of 12.5% The combined revised trajectory plan is still for these modalities to reach 5% from December 2026, reaching 10% in October 2026.
Gastroscopy	9.6%	19.9%	For Colonoscopy, Flexi-Sigmoidoscopy and Gastroscopy the deterioration in performance is solely related to reductions for Epic implementation, where activity was reduced to 50%. The service anticipated that the performance would deteriorate further before seeing an improvement owing to 6+ week breaches related to the reduction in activity for Epic. The position continues to recover for Flexi and Gastroscopy but Colonoscopy remains under pressure from higher than average USC referrals. This gives Endoscopy a mean percentage of 12.5%

			The combined revised trajectory plan is still for these modalities to reach 5% from December 2026, reaching 10% in October 2026.
Colonoscopy	18.8%	19.8%	For Colonoscopy, Flexi-Sigmoidoscopy and Gastroscopy the deterioration in performance is solely related to reductions for Epic implementation, where activity was reduced to 50%. The service anticipated that the performance would deteriorate further before seeing an improvement owing to 6+ week breaches related to the reduction in activity for Epic. The position continues to recover for Flexi and Gastroscopy but Colonoscopy remains under pressure from higher than average USC referrals. This gives Endoscopy a mean percentage of 12.5% The combined revised trajectory plan is still for these modalities to reach 5% from December 2026, reaching 10% in October 2026.
MRI	18.3%	18.3%	MRI remains challenged as demand is significantly outweighing capacity with weekly elective cancellations to meet emergency and inpatient demand. Whilst MRI has improved through data validation and waiting list management, inpatient demand will increase throughout Winter and the position will deteriorate. MRI will not become compliant with the DM01 target for March without additional capacity. A case is being worked up for additional capacity.
Neurophysiology	32.4%	21.7%	There has been an increase in EMG referrals from across the trust and unfortunately due to sickness the service has been unable secure additional capacity via our insourcing company. This is provided by RDUH. The service has been able to confirm 4 days in November with the current consultant, which will provide 32 outpatient and 4 inpatient slots
NOUS	25.2%	28.1%	NOUS has seen a further improvement. Additional capacity continues in NOUS, both from recruitment into posts, overtime, and outsourcing, this will continue with full recovery anticipated Feb 2027.
Urodynamics	8.0%	28.6%	Urodynamics has improved in September and is anticipated to continue to improve in October and November 2026

28. The Committee is asked to agree **limited** assurance against delivery of the 62-day and 28-day cancer performance targets, however, consider that **limited** assurance can be taken in the impact of the current recovery plans due to expected progress not being seen. The committee is also asked to agree **satisfactory** assurance on diagnostic performance at present based on consistent improvement in line with trajectory and discuss if **satisfactory** assurance can be taken on the plans that are in place to recover.

Assurance recommendations and summary

29. 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	Satisfactory
UEC Ambulance Handover	Limited	No Change	Satisfactory
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 within 18 weeks	Limited	No Change	Limited
Cancer Performance	Limited	No Change	Limited
Diagnostic Performance	Satisfactory	No Change	Satisfactory

NHS
Torbay and South Devon
NHS Foundation Trust

Presented to:	Finance and Operations Committee			
Title of Report	Monthly Finance Report			
Date of Meeting	28th October 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.			
Purpose of paper	**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 6 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 September shows a month end position of **£10.2m** deficit, as planned. The position excluding DSF is **£39.1m** deficit at the end of September, 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), a provision against contract income was made to recognise activity lost through EPR implementation (£1.6m adverse to plan), with a favourable variance on undrawn ERF reserve (£1.3m favourable). All other corporate and frontline budgetary variances totalled £2.2m adverse to plan, with £2.9m other favourable variances from undrawn reserves. EPR implementation 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£1.6m in the position. 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 submitted a Mid-Year forecast to NHSE confirming full commitment to plan delivery and including mitigations and recovery actions to secure this position. The Trust's month 6 forecast is consistent with this forecast as a best case forecast, but reflecting a gap to full plan delivery of £1.6m where the ASC/CHC position has deteriorated further and requires additional, not yet identified mitigation. The base case forecast recognises forecast risks to delivery of **£6.4m**, with up to **£14.9m** in the downside risk assessment (with £2.8m risk to the ULP in the base case and £12.7m in the downside risk assessment). The Trust will continue to work with operational leads,			

<table>
<tr><td></td><td colspan="6">NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and identify further mitigations to deliver the plan.

Year to date at Month 6 the Trust has recognised CIP delivery of £16.5m against a £16.5m target (£0.0m variance to plan). Since the plan was submitted intensive work is continuing to be undertaken on implementing the CIP plans. Fully developed plans have increased by £0.2m however, from a risk perspective, there has been a £2.2m increase in high level risk and a £3.2m increase in medium risk which demonstrates some of the emerging risks. The Trust is still forecasting full delivery of the £54.4m target.

The Trust is reporting a cash balance of £3.2m as at 30th September 2026, £15.1m lower than planned, primarily due to not drawing £10.193m PDC Revenue Support (per the plan to M06), with the remaining £4.9m shortfall primarily related to a receipt of £6.2m from Torbay Council after the ledger close. The Trust has now submitted an application for £10.193m PDC Revenue Cash Support in M07 for drawdown in M08 with the expectation to repay in full in M12, reflecting the agreed 2026/27 cash plan.

At Month 6 the Trust has spent £8.5m of capital compared to plan of £9.3m, an underspend of £0.7m. The Trust is forecasting to spend up to capital limits, including an additional £2.2m National PDC Capital including Tower Safety and SDEC schemes and an additional £0.5m adjustment to CDEL allocation.</td></tr>
<tr><td>Recommendation</td><td colspan="6">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.

The Finance and Operations Committee is requested to note the requirement for temporary cash support and APPROVE the request for £10.193k of Revenue PDC Support, as planned.</td></tr>
<tr><td rowspan="2">Link to Strategic Signature Moves</td><td>Living well in our neighbourhoods</td><td>Reimagining acute and specialist care</td><td>Caring, skilled people ready for tomorrow</td><td>Joined up care, every step of the way</td><td>Smart use of technology for better care</td><td>Foundation</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>☒</td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td colspan="6">This report supports the Trust's strategic objectives to achieve financial sustainability.</td></tr>
<tr><td colspan="7">Board Assurance</td></tr>
<tr><td>BAF Ref</td><td>Principal Risk</td><td>Current Score</td><td colspan="4">Impact of this paper</td></tr>
<tr><td>Finance C1</td><td>Risks to financial</td><td>12</td><td colspan="4">Robust financial information and forecasting is key to ensure the financial</td></tr>
</table>

Torbay and South Devon NHS Foundation Trust

	sustainability, CIP delivery and adequacy of cash balances are identified Trust risks.		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 or EDI implications?	None identified				
Assurance rating	Significant	Moderate	Limited	Inadequate	
		☒ Assurance on financial performance			
Assurance rationale	The Trust is on plan and delivering to target year to date.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
			☒ Assurance on CIP, forecast risks and workforce		
Assurance rationale	The Trust has risks to forecast on CIP and plan delivery.				
Appendices	Appendix 1 – Trust Run Rate Forecast Outturn Appendix 2 – Plan B Appendix 3 - 10 Point Recovery Appendix 4 – M06 Cashflow Forecast Appendix 5 – Treasury Analysis *Appendices in the Committee's Items for Information Pack*				

Committee Chairs' Report – 27th October 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:

- **Thirlwall Inquiry Recommendations: Implementation and Assurance Approach** – Moderate assurance
- **Board Assurance Framework and Corporate Risk Register Quarter 2 Progress Summary (July–September 2026)** – Limited assurance
- **Workforce Plan Mid-Year Review** – Limited assurance
- **Freedom to Speak Up Mid-Year Review** – Moderate assurance
- **Cultural Insights Review Group (CIRG): Organisational Change, Focused Team Support and Culture Assurance Report** – Limited assurance
- **Internal Audit Report – Follow-Up of Deprivation of Liberty Safeguards (DoLS)** – Moderate assurance
- **NHSE Quality Strategy Findings and Recommendations Paper** – Limited assurance
- **Quarter 2 (Q2) Perinatal Quality and Safety Report** – Limited assurance
- **Safeguarding Adults Annual Report 2025–2026** – Limited assurance
- **Single-Handed and Fragile Clinical Services – Assurance Report** – Limited assurance
- **Research & Development (R&D) Annual Report 2025/26** – 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:	The tower block fire safety work is being monitored for its impact on quality of care and the potential to increase instances of corridor care particularly in relation to availability of adult inpatient overnight beds. Bed modelling and patient flow work (SDEC, pre-noon discharge, LOS) is underway. QPC will receive update in November.

	The BMA Consultants Committee has announced industrial action on 26th/27th November. Impact at the Trust is yet to be understood but there is potential risk to patient flow through wards and trauma lists. Committee approved the Maternity Care Bundle implementation plan, governance and trajectory to full compliance in March 2027. QPC will have quarterly oversight. H2 review of workforce plan shows substantive underspend of £1.94m, Bank overspend of £1.84m and Agency overspend of £0.51m. Whilst there is a lot of credible activity described within the H2 review it is difficult to discern, with clarity, what the activity will contribute to the forecast reduction of 199 WTE and £3.7m pay expenditure between M6 and M12. Against a backdrop of 18 organisational change programmes, transition of adult social care services and associated TUPE, Tower Block fire safety work, sustained sickness levels above target and behavioural and conduct concerns, Board is asked to acknowledge this challenging environment and to consider appropriate review and sequencing of organisational change priorities.
ADVISE:	Research and Development Annual and Interim reports will be taken at Board in future to allow for broader scrutiny and alignment of growth opportunities to Trust strategy. The Trust's new Freedom to Speak Up service has commenced with externally employed guardians providing an independent and confidential route for staff to raise concerns.
ASSURE:	Thirwall Inquiry Recommendations – clear implementation and assurance framework with Executive ownership of all but one workstreams (**see risk below re: digital, intelligence and early warning systems**). This will be positioned as a Board level patient safety improvement programme within existing governance structures. QPC will have oversight in January 2027 before first national deadline (March 2027). The Single-Handed and Fragile Clinical Services assurance report was welcomed by committee. It set out a control framework to actively manage risk within single-handed and fragile services with escalation to TEG and by exception to QPC. CMO to share this work to inform 27/28 business planning service sustainability work. Good discussion on need for system-wide mechanisms to

	support fragility across services including collaborative resourcing. ICB colleague agreed to share paper with ICB CMO. NHSE Quality Strategy – clear, phased 16-month implementation plan for a Trust wide Quality Management System with joint executive sponsorship (CNO/CMO). The standard against which gap analysis for the QMS is to be identified has not yet been selected. ISO 7101 was noted as being a QMS standard specifically for healthcare. **See risk below re: digital, intelligence and early warning systems**. Safeguarding Adults Annual report provided evidence of active management controls and an improving trajectory, particularly for DoLs against a complex legal system. Good evidence of collaborative approach through the Torbay and Devon Safeguarding Adult Partnership and it is imperative this remains the case as we navigate transition of the S75 arrangements. Internal Audit Report - follow-up on Deprivation of Liberty Safeguards provides assurance of substantial improvement since previous audit. Controls and processes are having a material positive impact on backlog and outstanding applications.
RISK:	Current risks within the Perinatal report that Board should be aware of: • maternity workforce and acuity indicators deteriorated during Q2: increased vacancy rate and sickness levels, difficulty in staffing triage, workforce controls delaying recruitment. Workforce and DAU/triage capacity review underway. • Major obstetric haemorrhage remains above the national average. Thematic review has identified improvement opportunities with actions progressing through established governance. QPC will maintain oversight. • Data quality and digital resilience are limiting some of the assurance that can be provided. **See risk below re: digital, intelligence and early warning systems**. **Digital, intelligence and early warning systems**: across several QPC papers this month (and last month's Chair report also alerted Board to this) there is a recurring theme relating to capacity and capability gaps in digital and business intelligence. Without a cohesive data, digital and intelligence strategy there is a risk that efforts within this space are diluted, misdirected and under-invested resulting in an inability to triangulate data and inadequate early warning systems pertaining to quality of care.

	QPC asks that Board schedules time to discuss this particularly in light of commitments outlined to meet the requirements of the Thirwall Inquiry recommendations and NHS England's Quality Strategy. To also understand support available from national digital teams.
CELEBRATE OUTSTANDING:	National recognition from the Royal College of Obstetricians and Gynaecologists – highly commended for professional development in the small-hospital category and most improved unit. TSDFT is nationally recognised for its research within cancer studies. The first UK site to recruit into global lung and prostate cancer studies and among the first to open a new triple-negative breast cancer trial - offering our patients access to new therapies and treatments.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Quality People Committee**			
Title of Report	Quarter 2 (Q2) Perinatal Quality and Safety Report			
Date of Meeting	**27/10/2026**	**Author**	Joanna Bassett Director of Midwifery and Child Health (DCNO)	
Executive Lead	**Nicola Mcminn CNO** **Kate Lissett CMO**	**Executive Sign Off**	Nicola Mcminn CNO	
Governance Route	Perinatal Governance Committee, Perinatal Safety Champions and Perinatal Improvement Board			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		x	x	
Executive Summary	The purpose of the report is to provide the Committee with a summary of the information and metrics contained within the supplementary perinatal safety and governance report (Quarter 2 2026). It is to alert, advise and assure with key risks highlighted along with celebration of successes. The purpose of the perinatal governance report (**appendix 1)** is a required component of the maternity reporting framework for NHS England (NHSE) and aims to assure the committee on critical elements of the maternity safety agenda by. • Outlining the Trust position on perinatal mortality and morbidity • Reporting progress and compliance with priority areas of focus. • Provide system level assurance on perinatal quality and safety. This executive summary paper was requested by the Executive committee alongside the Board Level Non-Executive Safety champion so that visibility and oversight of key risks was clear with mitigations apparent. This report includes the following assurance recommendations:			
Recommendation	• Note the overall progress and key risks, particularly maternity workforce and acuity, major obstetric haemorrhage, screening and digital resilience, and data quality. • Approve the Maternal Care Bundle Implementation Plan and Governance and Reporting Framework, endorse the trajectory to full implementation by March 2027, and agree quarterly oversight.			

	• Support the service, where required, to overcome workforce, capacity, digital, training or cross-organisational barriers that may affect delivery. • Note and celebrate the national RCOG recognition of Torbay as the most improved training unit.

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	This paper will contribute to the Trust's strategic moves by assessing and demonstrating quality and safety, reducing inequalities, strengthening workforce capability, enhancing partnership working and ensuring that women, babies and families remain at the centre of service improvement and decision-making.

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	This paper will enable the service to demonstrate board oversight and reporting that aligns with the requirements of the Maternity Incentive Scheme and the Perinatal Quality Oversight Model.
Ethical or EDI implications?	Workforce pressures and service restrictions may affect choice, access and experience. Decisions will remain clinically justified, proportionate and regularly reviewed, with outcomes monitored to identify and address any inequalities.

Assurance rating	Significant	Moderate	Limited	Inadequate
		X		

Assurance rationale	The Board can be partially assured that perinatal safety and governance controls operated throughout Quarter 2. Assurance is moderated by deterioration in maternity workforce and acuity indicators, major obstetric haemorrhage above target, open review actions and data-quality limitations.
Appendices	Appendix 1- Quarterly Perinatal Trust Board Safety Report Appendix 2- Maternal Care Bundle Implementation Plan Appendix 3- Maternal Care Bundle Governance and Reporting Framework *Appendices are in the Committee Items for Information Pack*

Perinatal Quality and Safety Report – Executive Summary.

1.0 Introduction and background

The purpose of the report is to provide the Committee with a summary of the information and metrics contained within the Quarter two supplementary perinatal safety and governance report (**appendix 1**). It is to alert, advise and assure with key risks highlighted along with celebration of successes. This 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 supplementary 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 supplementary report has moved to the NHS Resolution Board reporting template to ensure alignment with the requirements of the Maternity Incentive Scheme (MIS).

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

2.0 Alert/Risks

2.1Maternity workforce and acuity indicators

Maternity workforce and acuity indicators deteriorated during Q2, with red flags increasing as well as a reduction in the staffing to acuity ratio on both the antenatal postnatal ward and on labour ward. The midwifery vacancy rate also increased to 6.12% in September, with additional pressure from variable maternity support worker fill rates. There was also an impact on the ability to fill the shifts required to staff triage. This reflected an increase in sickness absence alongside the planned movement of preceptee midwives into their next posts, which created a temporary gap in rostered capacity during September while replacement recruitment and deployment arrangements were progressed. It has also been noted that workforce controls in place within the organisation are delaying efficient and timely recruitment of replacement posts which is contributing to the pressures experienced. This is also impacting on the senior midwifery leadership team who are having to manage this and provide support outside of usual working hours.

Daily staffing reviews, redeployment and senior escalation controls remained operational. A workforce and DAU/triage capacity review is being progressed to address the identified pressures and support a sustainable recovery trajectory.

2.2 Data Quality and digital resilience

Data quality and digital resilience are a concern and currently limit some of the assurance that can be provided. Although the maternity team has developed its own triage dashboard to improve operational visibility, BI and EPIC data-quality issues continue to affect the completeness, reliability and timely reporting of key safety metrics. This is compounded by a single-point dependency within the Digital Midwife function and increasing screening failsafe issues, creating a risk to oversight, statutory reporting and timely identification of potential gaps in care. Six months of targeted NHS England support from the national screening team has been offered and is intended to provide short-term specialist capacity to address increasing failsafe issues, review and correct data inaccuracies, strengthen cross-organisational screening pathways and ensure timely follow-up of women and babies. It will also support the team to standardise processes, clear any outstanding actions, improve reporting and transfer knowledge to the substantive team so that a sustainable and resilient screening service is established.

2.3 Major Obstetric Haemorrhage Rate

The rate of major obstetric haemorrhage (PPH >1500 ml) remains above the national average and is a principal clinical concern, with a rate of 4.77% reported in September. A thematic review of 28 cases identified opportunities to strengthen consistent cumulative blood-loss measurement, timely escalation and use of the PPH proforma. Improvement actions are in progress through established perinatal governance arrangements, with ongoing monitoring of compliance and outcome data. The committee is asked to note the elevated rate and maintain oversight until there is sustained evidence of improvement.

3.0 Advise

3.1 Maternal Care Bundle Implementation Plan

The Maternal Care Bundle (MCB) implementation plan and supporting governance and reporting framework (**Appendix 2 and 3)** have been developed to provide a structured route to full implementation of all 14 interventions across the five clinical domains by March 2027. Delivery will be monitored monthly through the Perinatal Assurance Meeting and Perinatal Governance Committee, with safety themes and

barriers considered through the Perinatal Safety Champions Committee and material exceptions escalated through established quality governance routes. The committee is asked to approve the implementation approach and governance and reporting framework; endorse the trajectories to full compliance by March 2027; and agree quarterly committee oversight of implementation status, action-plan progress, risks, evidence validation and delivery confidence before onward assurance to Trust Board. Where trajectories are not met, or compliance falls below agreed thresholds, recovery actions and any resource or cross-organisational barriers will be escalated for committee scrutiny and executive action.

3.2 MOSS drill

A multidisciplinary Maternity Outcomes Signal System (MOSS) tabletop drill was undertaken on 28 September 2026 to test the Trust's readiness to respond to a simulated safety signal, including communication and escalation routes, rapid review, completion of the Critical Safety Check and executive oversight. The exercise confirmed established governance arrangements, effective engagement from the perinatal leadership team and active monitoring of key safety indicators. The overall outcome was rated **Amber**, reflecting known safety gaps where improvement plans are in place, but standards are not yet being achieved consistently or at the required pace. The principal findings related to review of new maternity triage presentations within 15 minutes, timely commencement of induction of labour, full multidisciplinary representation at labour ward huddles and consistent structured handover. Actions include delivery of the triage improvement plan and approved staffing uplift, a time-bound induction improvement plan, testing a revised morning huddle with neonatal/paediatric representation from November, and strengthening SBAR handover within EPIC. The completed Critical Safety Check has received executive review and has been shared with ICB and regional partners. Progress will be monitored through the Labour Ward Forum, Perinatal Governance Committee and Perinatal Safety Champions Committee, with the Committee asked to maintain oversight until actions are demonstrably on track and sustained improvement is evidenced.

3.3 Publication of the Thirlwall Report

The Thirlwall Inquiry report, published on 15 September 2026, identified serious failures in safeguarding, leadership, governance, escalation and organisational response to concerns at the Countess of Chester Hospital, with learning relevant to all NHS trusts and integrated care boards
Immediate national work includes strengthened safeguarding and neonatal-death processes, safer medicines management, bereavement support, consideration of cot-camera arrangements and a single tracker for recommendations from major maternity and neonatal reviews. A multidisciplinary Trust working party has been established to coordinate the local response, undertake a structured gap analysis against the recommendations, triangulate findings with the existing Perinatal Improvement Plan and 10 Point Plan, and maintain a single action and assurance

tracker. The working party will identify any additional actions, leads and timescales and report progress and exceptions through established governance routes. The Committee is asked to note the report, the establishment of the working party and the continued Board oversight of the Trust response.

4.0 Assure

4.1 Operational performance metrics

In line with strengthened oversight requirements, the service has commenced routine reporting of temporary service suspensions and restrictions to improve visibility of the impact of workforce and capacity pressures on access, choice and flow. This is captured as part of the national daily operational situation report. During Q2, the obstetric unit remained open throughout. Midwifery-led unit and homebirth provision were suspended on occasions when staffing and acuity pressures meant that midwives could not safely be released from the acute site; this increased in September, with 14 recorded occasions for each service. Women were offered midwifery-led care within the obstetric unit, including the birthing pool where appropriate, and capacity was reviewed throughout the day to support prompt reinstatement. No complaints or associated adverse outcomes were reported, although some women's planned place-of-birth choice was affected. The neonatal unit had no internal suspensions; external cot capacity was restricted on three occasions during Q2, requiring clinical prioritisation and regional network escalation. The Committee is asked to note the inclusion of this reporting through this paper, the September increase and the link to wider workforce and acuity pressures. Trends, duration, impact and contributory factors will continue to be monitored through operational and perinatal governance routes, with escalation if restrictions become sustained or indicate deterioration in service resilience.

4.2 Core safety and governance controls

Core safety and governance controls remained operational throughout Q2. Weekly review of incidents and open cases, Duty of Candour, PMRT oversight, guideline governance, audit and action tracking continued through established perinatal governance routes. Operational assurance is supported by 100% Labour Ward coordinator supernumerary status across the quarter, sustained obstetric consultant cover where reported, no use of obstetric consultant locums, improving fetal monitoring compliance and largely maintained neonatal staffing compliance. Reviews also identified examples of timely multidisciplinary escalation and compassionate care, reflected in positive feedback from women and families. Assurance remains moderate rather than significant because the volume of open reviews, guideline backlog, training gaps and data-quality limitations constrain evidence of timely action closure and sustained impact. The Committee is asked to note that the core control framework is functioning and to maintain oversight of outstanding actions and evidence of improvement.

5.0 Celebrating Success

5.1 Trainee feedback RCOG

Torbay has received national recognition through the Royal College of Obstetricians and Gynaecologists' (RCOG) 2026 Training Evaluation Form Awards, being highly commended for professional development in the small-hospital category and recognised as the most improved unit. The award reflects the greatest improvement in trainee feedback since the 2025 results across indicators including educational supervision and support, clinical and procedural training, professional development, clinical governance, working environment, behaviours and wellbeing. This is a significant achievement and provides external validation of the work undertaken by the multidisciplinary team to strengthen the training environment and trainee experience. To sustain and build on this progress, the service is repeating its mapping of Capability in Practice opportunities against those achieved by each training grade, with a further trainee pulse review informing continued improvement and assurance to NHS England.

6.0 Assurance recommendations and summary

The Committee is asked to note and agree the assurance recommendations and confirm that this executive oversight report, together with the supplementary report at Appendix 1, provides sufficient visibility of the key perinatal quality and safety issues, controls and mitigations.
The committee is also asked to:

- Note the overall progress and key risks, particularly maternity workforce and acuity, major obstetric haemorrhage, screening and digital resilience, and data quality.
- Approve the Maternal Care Bundle Implementation Plan and Governance and Reporting Framework, endorse the trajectory to full implementation by March 2027, and agree quarterly oversight.
- Support the service, where required, to overcome workforce, capacity, digital, training or cross-organisational barriers that may affect delivery.
- Note and celebrate the national RCOG recognition of Torbay as the most improved training unit.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Moderate/Significant)	Position and direction of travel

2.1 Maternity workforce and acuity	Limited	Deteriorating indicators in September; daily controls remain active and workforce and triage capacity review is progressing.
2.2 Data quality and digital resilience	Limited	Assurance remains constrained by BI/EPIC data quality, screening failsafe issues and single-point digital dependency; targeted support is planned.
2.3 Major obstetric haemorrhage	Limited	Rate remains above the national average; thematic review is complete and improvement actions are under governance oversight.
3.1 Maternal Care Bundle	Moderate	Implementation plan and governance framework are established; Committee approval and quarterly oversight are required to support delivery by March 2027.
3.2 MOSS drill	Moderate	Amber drill outcome confirmed functioning escalation arrangements, with improvement actions required for triage, induction, huddles and handover.
3.3 Thirlwall report	Moderate	A multidisciplinary working party is coordinating the gap analysis, action tracker and assurance reporting;

		local assessment is in progress.
4.1 Operational performance metrics	Moderate	The obstetric unit remained open, but midwifery-led and homebirth suspensions increased in September; monitoring of frequency, duration and impact has commenced.
4.2 Core safety and governance controls	Moderate	Core controls are functioning, but open reviews, guideline backlog, training gaps and data limitations restrict evidence of sustained impact.
5.1 RCOG trainee feedback	Significant	National recognition as the most improved unit provides external validation; further mapping and trainee pulse review will support sustained progress.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Quality and People Committee**		
Title of Report	**September 2026 Mortality Scorecard**		
Date of Meeting	22 September 2026	**Author**	Mr Chris Manlow, Director of Patient Safety; Yvonne Paulucy, Deputy Head of Compliance and Assurance
Executive Lead	Chief Medical officer	**Executive Sign Off**	15th Sept 2026
Governance Route	Mortality Surveillance Group; Patient Safety Group; Quality and People Committee		

Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		X		X

Executive Summary

The report is for quarterly assurance to ensure learning from deaths.

IMPORTANT NOTE: This report has been produced with limited data due to the end of the trusts contract with Telstra/Dr Foster and the gap in data provision prior to the introduction of the HED system.

Key Highlights mortality indicators:

1. SHMI is 98.18 and statistically as expected. Slight upward trend over the last two months.
2. HSMR is 99.3 and statistically as expected. Slight upward trend.
3. Trust crude death rate is 3.13 %. Regional crude % – 2.12%, and National % – 2.13%. Trend is down.
4. There are no CUSUM alerts available for this period due to the end of the Telstra/Dr Foster contract. However, all ten key monitored SHMI diagnostic groups are showing as expected.

For Escalation:

5. The trusts contract with Telstra (Dr Foster) came to an end in April 2026 with the trust moving over to the HED system which is widely used by regional peers. This system is not yet in place and hence some data normally used to comply this report was not available. The data reported in this scorecard is thus limited. It is planned for the HED system to be in place soon.
6. The Trust is not assured that all cases requiring a structured judgment review are being reviewed. Despite significant work on the SJR process there is still work to do to ensure

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	consistent and timely use of the SJR methodology in Mortality reviews across the trust. Work continues to ensure clinician engagement with the process. 7. Mortality coding: The introduction of the EPIC EPR has introduced some coding anomalies which have started to affect our data quality. These anomalies were expected and should be resolved as EPIC becomes more established, and the issues are worked through. High activity has also compounded these issues resulting in an increased volume of uncoded activity.
Recommendation	The committee is asked to: • receive and note the mortality data and analysis; •• support timely implementation of HED; • request continued senior medical leadership to improve timely completion of SJRs; and • note the potential effect of coding anomalies and uncoded activity on mortality data quality.

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

How this paper supports delivery of the Strategy	Reviewing care following death and learning from bereaved families supports improvement in quality, safety and patient experience. HED supports better mortality intelligence; timely SJRs support organisational learning and clinical improvement.

Board Assurance			
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
Quality and patient experience: personalised care		16	The paper identifies gaps in assurance arising from limited mortality intelligence, delayed SJRs and coding-related data-quality risks.

Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
	X			X	X

Compliance / Regulatory Requirements	National Guidance on Learning from Deaths; Care Quality Commission requirements for oversight and learning from deaths.
Ethical or EDI implications?	No specific ethical or equality, diversity and inclusion implications are identified. The report includes learning from deaths of people with a learning disability and autistic people.

Assurance rating	Significant	Moderate	Limited	Inadequate
			X	

Assurance rationale	Limited assurance: mortality indicators are within expected ranges, but assurance is constrained by incomplete mortality intelligence, 38 outstanding SJRs and coding-related data-quality risks.
Appendices	None.

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September 2026 Mortality Scorecard Summary Report

Introduction

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

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

Summary

Torbay & South Devon NHS Foundation Trust Data

Safety Indicator	Data Source	Target	RAG
Hospital Standardised Mortality Ratio (HSMR+) July 25 to June 26	HED latest data	Below the 100 line with an aim for a yearly HSMR+ ≤90	99.3 Expected Range
Summary Hospital Mortality Index (SHMI) June 2025 to May 2026	DH SHMI data	Within the 'as expected' Range	98.18 Expected Range
SHMI alerts	DH SHMI data		None of the 10 SHMI monitored diagnosis groups are statistically higher than expected
Mortality Analysis	Trust Data Dr Foster/HED DH HSMR data	New CUSUM alerts SHMI Groups	Limited Data No CUSUM Alerts

Note as previous report due to lack of data			SHMI groups as expected
Mortality Reviews and Learning	Trust Data	Deep dive work has been commissioned regarding stroke deaths, cardiac failure, sepsis and Surgical mortality.	Work is progressing on course

Assurance and Recommendations

Section	**Assurance (Limited/Satisfactory/ Significant)**	**Trend from the previous report**
Hospital Mortality	Satisfactory	Slight Increase in both SHMI and HSMR
Unadjusted Mortality Rate	Limited	Has increased. Higher than peers and nationally. Trend down
Mortality Analysis	Satisfactory	No CUSUM alerts available SHMI monitored groups as expected
Focused Mortality Reviews	Satisfactory	Review underway regarding sepsis, stroke, surgical, cardiac failure

Recommendations

Members of the Quality and People Committee are asked to:

1) to receive and note the mortality data and analysis, including the implications for patient safety and quality.
2) discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.

3) Note the challenges in the completion of structured judgement review cases on the incident reporting system and request continued medical leadership to encourage medical engagement.
4) Note the challenges in mortality analysis caused by the gap in procurement of the HED mortality system after the end of the Telstra/Dr Foster contract.

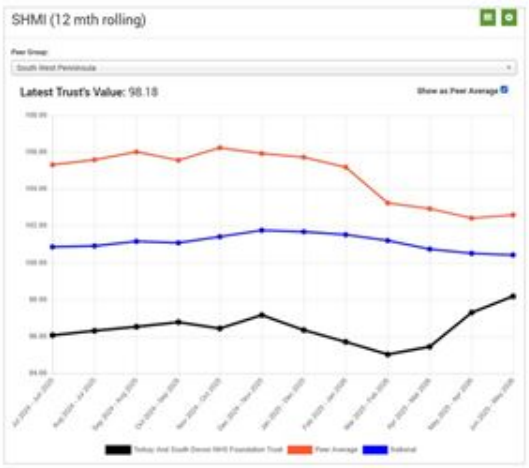
1.0 Mortality coding:

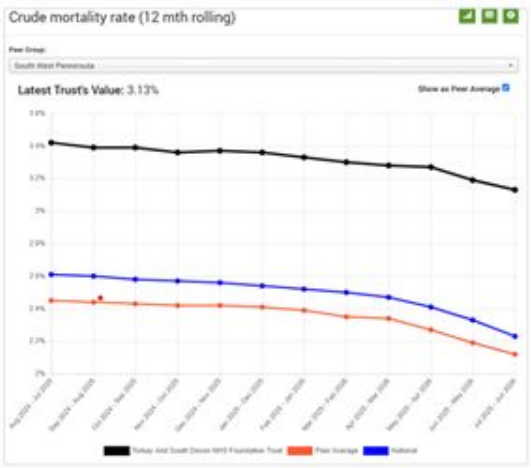
In the long term It is expected Epic will have a positive impact on mortality statistics as the depth and accuracy of coding increases. It is to be expected that there are some initial anomalies reflected in the coding after the introduction of an Electronic Patient Record-this is reflected in trusts nationally after the introduction of a new system.

The coding position remains positive with quarter 1 completely coded, however as activity increases this is starting to impact the number of uncoded episodes-this in turn will affect the quality of our mortality data. Progress is being made to resolve the current ongoing vacancies in coding, two positions have been filled and there are two interviews pending.

2.0 Mortality data and trends

- The latest HMSR+ for July 25 to June 26 is **99.3**. This is within the expected range. Peer is 97.34. National is 100.7.
- Latest SHMI data for the data period June 2025 to May 2026 is **98.18.** This is within the expected range. Peer is 102.59. National is 100.42
- Crude Mortality rate is **3.13**%. Peer is 2.12%. National is 2.23%.

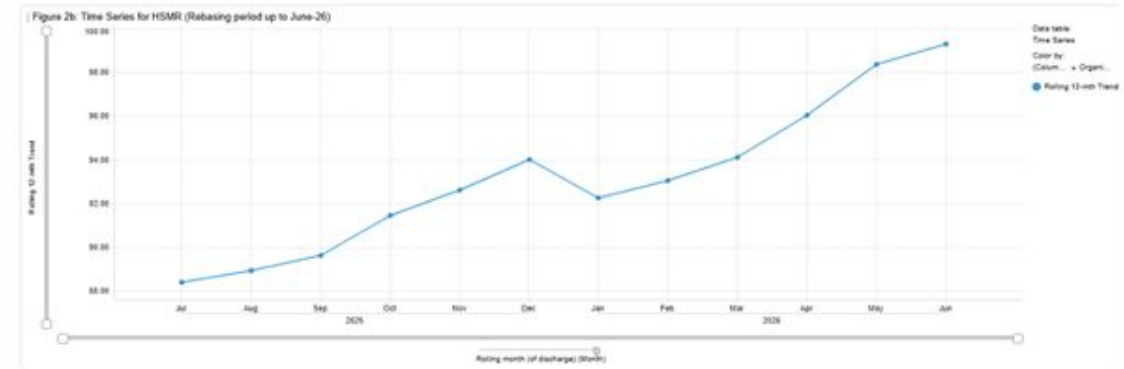




While SHMI (12-month rolling) is moving in a different direction to peers (average) & national this is not due to increase in deaths – see second chart where the trusts crude mortality is reducing over time.

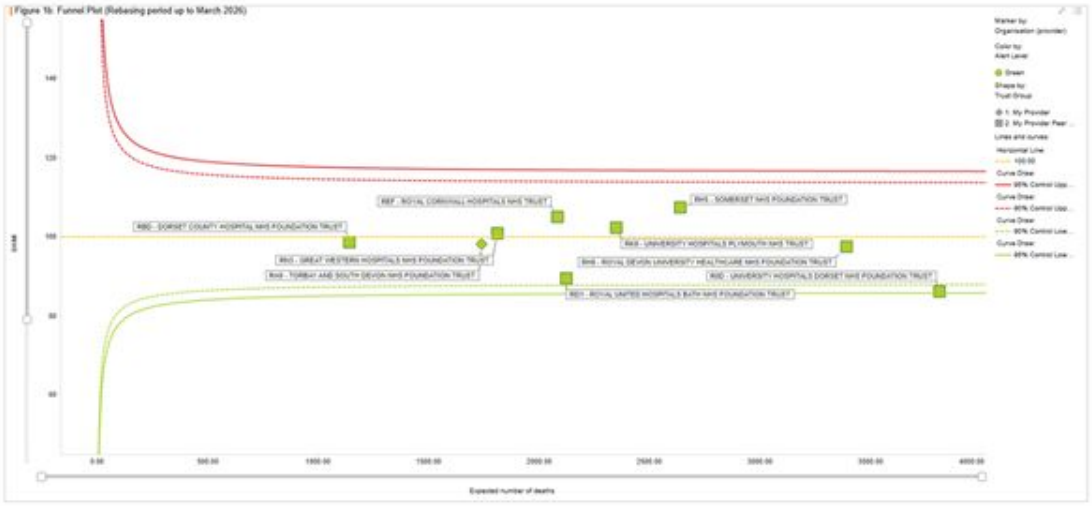
Note recent trend for increasing SHIMI, this is driven by a reduction in the expected number of deaths not an increase in deaths. This is similarly seen in the rolling HSMR data.

HSMR – latest rolling 12-month value (July 25 – Jun 26)



Peer comparison is shown below:

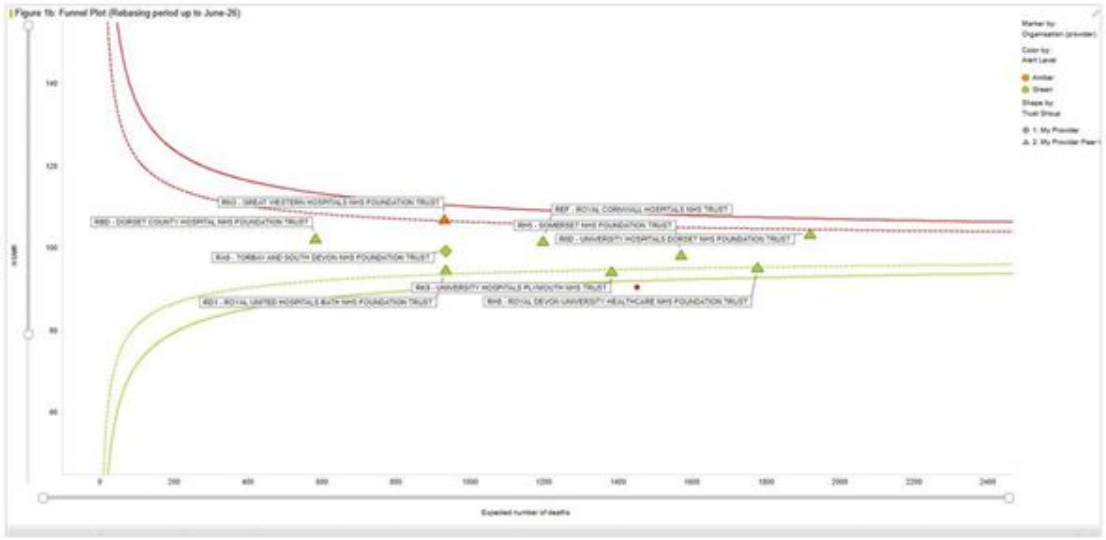
Overall SHMI compared to peer group – May 25 - June 26.
The trusts value is below expected and shown in green.



Torbay and South Devon NHS Foundation Trust

HSMR – latest rolling 12-month value (July 25 – June 26)

The trusts value is below expected and shown in green.



2.1 CUSUM/SHMI Alerts

CUSUM/SHMI alerts are used to highlight patterns of increased deaths in specific diagnosis groups. This can then trigger deep dives into specific areas of care to analyse any issues.

Due to the gap between the provision of Telstra/Dr Foster reports and the new HED system there are no new CUSUM alerts.

NHS data highlights that in the 10 diagnostic groups monitored by SHMI mortality is as expected with no outliers. This is reassuring.

We currently have more detailed work ongoing looking at Congestive Cardiac Failure, Stroke and Sepsis.

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3.0 Focused Mortality Reviews

Mortality review work looking at the effect of long waits in the ED has been ongoing since 2022. The data shows that whilst overall mortality has improved and is now at pre-Covid levels, for elderly patients waiting for more than eight hours for a bed mortality has actually increased and is statistically significant in patients over 90 years. This increase has been sustained over the last few years. We are developing a suite of Metrics to monitor Mortality in our Non-Elective pathway. The procurement of the HED platform will be key in the development of this.

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

4.0 Perinatal mortality (Quarter 2 and 3).

4.1 This reports details perinatal still births or neonatal deaths in quarter 1 (April – June 2026).

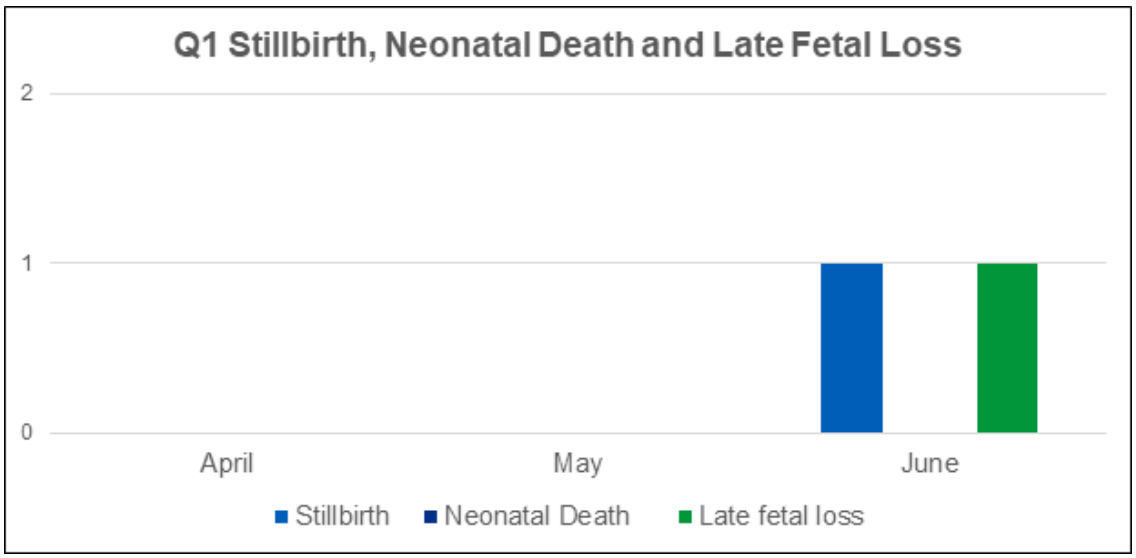
Definitions.

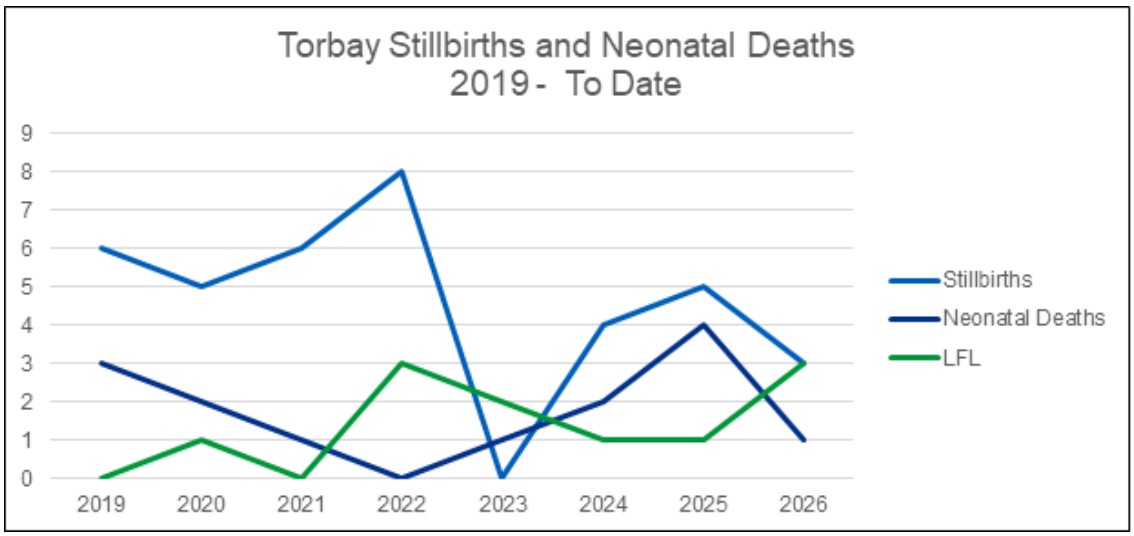
- Stillbirth: when a baby is born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.
- Early neonatal death**:** the death of a newborn within the first seven days of life.

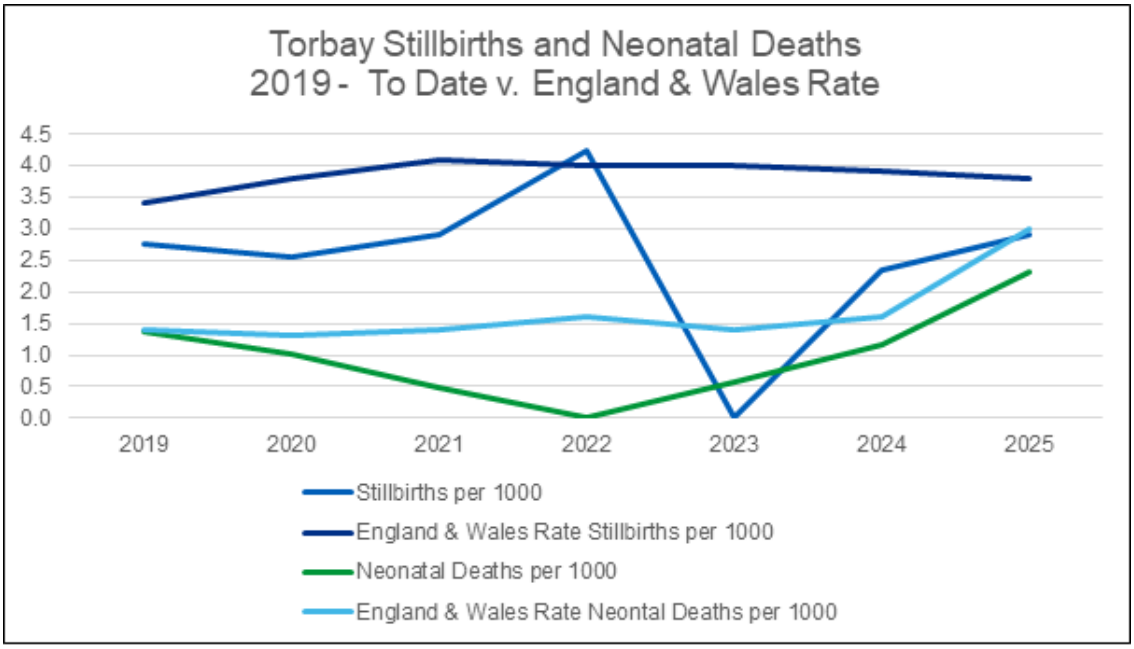
Cases that meet criteria have been referred Maternity and Neonatal Safety Investigations (MNSI) for review, a perinatal mortality review tool (PMRT) meeting will also be held. The Trust is also continuing to undertake a patient safety incident investigation into a Jan 26. Key themes were identified and actions produced to be managed under the Maternity and Neonatal Improvement Support Team (MNIST) action tracker.

The chart below shows the cases of stillbirth, neonatal death and late fetal loss in Q1. The second chart depicts mortality rates since 2019. The third chart is a comparison between Torbay and South Devon NHS Foundation Trust Stillbirth and Neonatal death rates and the national average for England and Wales per 1000 births.

Torbay and South Devon NHS Foundation Trust







4.2 Q1 Perinatal mortality cases:

There were no perinatal loses in April, May 2026.

June 2026: One stillborn baby born at 27/40 delivered at Torbay. Mother with severe HELLP syndrome. Reviewed under the PMRT and no care issues identified. Parents to be invited for debrief with an Obstetric Consultant.

June 2026: One late fetal loss at 21/40 weeks gestation. Woman had rescue suture at 20/40 but sadly went into labour and delivered a stillborn baby. Being reviewed as a PSR 1.

4.3 Perinatal mortality actions:

All outstanding actions from perinatal mortality incidents are being added to the relevant datix and are being managed via the overarching maternity action tracker.

5.0 Child Deaths

During Quarter 1 2026/27, four child deaths were reported, comprising one unexpected death and three expected deaths. The unexpected death involved a child who had transferred out of

the local area, with the Child Death Review being led by Bristol. All three expected deaths related to infants whose care involved specialist centres outside Torbay and South Devon, with reviews being led by Derriford and Bristol where appropriate. No local Child Death Review meetings were held during Quarter 1.

6.0 Medical Examiner Service

The independent Medical Examiner's Office hosted at TSDFT now scrutinises 100% of the deaths in the hospital and community settings, which are not directly referred to the coroner. In October 2025 the medical examiners mechanism for reporting deaths transferred to the Trust DCIQ incident reporting system. Medical Examiners can trigger an in-depth review of a case via the Structured Judgement Review module on Datix (See below). The Medical Examiner team are invited to attend the quarterly Mortality Surveillance Group and we continue to refine and improve our interface with the service.

7.0 Deaths of a patient with a Learning disability or Autism

Q1 to Q3 Update, 2026/27

People with a learning disability continue to experience significant health inequalities that are not necessarily in our Trust, including substantially reduced life expectancy compared with the general population. The Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) programme provides a structured approach to reviewing deaths, identifying learning and supporting improvement across health and care services.

Deaths occurring within acute and community hospital settings are also subject to scrutiny through the Medical Examiner system and, where indicated, may progress to further review through the Trust's mortality governance arrangements. This supports the early identification of concerns relating to care quality, avoidability and opportunities for organisational learning.

The 2026/27 LeDeR tracker currently contains seven populated death records. The populated records relate to deaths occurring between 27 April and 11 June 2026, and all seven cases are recorded as open.

Based on the seven populated records:

- Six patients were male and one was female.
- Ages at death ranged from 49 to 75 years.
- Four patients were aged under 65 and three were aged 65 or over.

- Three deaths occurred in an acute hospital, two in a care home, one in a nursing home and one in the person's own home.
- All seven cases have a recorded a LeDeR referral or reference number.
- No cases relate to any safeguarding concerns.
- No case is currently recorded as closed, as awaiting ICB closure of their LeDeR review process.
- All cases have had an internal Structured Judgement Review (SJR) completed.

Respiratory and aspiration-related conditions feature in several of the recorded causes of death, including aspiration pneumonia, pneumonia and lower respiratory tract infection. One death records hypoxic-ischaemic encephalopathy secondary to cardiac arrest, and one records adenocarcinoma of an unknown primary source. These observations should be treated as an emerging pattern for review rather than a confirmed recurring theme, pending completion of the relevant LeDeR and mortality reviews. The LeDer programme is conscious of the number of infections of the cause of death and would like to see this number reduced nationally as it is thought that some of these are potentially preventable.

Senior oversight of this area has transitioned to Natalie Herring, Deputy Chief Nurse, to support continued clinical leadership, assurance and the translation of learning into improvement.

The Board is asked to note that seven populated deaths are currently recorded for 2026/27 Q1-Q3, with all cases showing evidence of LeDeR referral. All cases remain open under ICB LeDeR review process who will provide feedback regarding avoidability, quality-of-care findings or recurring themes although through internal security, SJRs and internal LeDer reviews there is no indication that the Trust will receive any such recommendations. Further assurance will be provided as the ICB undertake their LeDeR review process.

The Learning Disability and Autism Programme (LD+A) follows national guidance, and the trust is in adherence to this through local action plans and the internal LD+A governance structures.

8.0 Learning from deaths & structured judgment review

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

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

Over the last year since September 2025, seventy-six Structured Judgement reviews (SJR's) have been requested to review the quality of care. Twenty-three of these were triggered by the Medical examiners and ten were triggered because of concerns raised by staff or family members.

Of these seventy-six SJR's, thirty-eight SJR's are at the time of writing awaiting completion. Completed SJR's over the last year have not highlighted poor care as an overall factor in any of the deaths identified. This is reassuring.

The Trust's patient safety team is not currently assured that An SJR is being completed for all appropriate cases in a timely manner. The patient safety team will work with the medical examiner team and clinicians to provide assurance that all deaths escalated by the medical examiner service have been reviewed appropriately.

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

A recent review of mortality themes gathered from multiple specialty presentations at the MSG highlighted a number of common themes in mortality:

- Delays in Care across all areas
- Increasing clinical complexity of patients and lack of Frailty resource
- Lack of Critical Care capacity
- Human Factors-Burnout/Exhaustion/Staffing/Communication
- Lack of Governance resource

9.0 Challenges/Risk

The trusts contract with Telstra/Dr Foster ended in April 2026. The intention was that the trust would move to the HED system which is also utilised by many of our peers.

Unfortunately, the new system is not yet in place. The trust is able to monitor and report vis basic NHS data systems however the trust has limited Mortality data and analysis tools with which to draw conclusions without the new system. It is anticipated that the new system will be procured and in place shortly.

The Trust is not assured that all cases requiring a structured judgment review are being reviewed. Despite significant work on the SJR process there is still work to do to ensure consistent and timely use of the SJR methodology in Mortality reviews across the trust. Work continues to ensure clinician engagement with the process.

Mortality coding: The introduction of the EPIC EPR has introduced some coding anomalies which have started to affect our data quality. These anomalies were expected and should be resolved as EPIC becomes more established and the issues are worked through. High activity and coding capacity has also compounded these issues resulting in an increased volume of uncoded activity.

10.0 Recommendations

Members of the Quality and Peoples committee are asked to:

- to receive and note the mortality data and analysis, including its implications for patient safety and quality.
- discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.
- There has been a gap in Mortality data caused by the end of the Telstra/Dr Foster contract and the procurement of the HED system. The trust has limited Mortality data and analysis tools with which to draw conclusions without the new HED Mortality system. The committee is asked to support the timely procurement of this platform

- Despite significant work on the SJR process there is still work to do to ensure consistent and timely use of the SJR process in Mortality reviews across the trust. Support from senior medical leadership is needed to ensure this improves.

- The introduction of the EPIC EPR has introduced some coding anomalies which have started to affect our data quality. These anomalies were expected and should be resolved as EPIC becomes more established. High activity and capacity issues has also compounded these issues resulting in an increased volume of uncoded activity. This may also affect data quality. The committee is asked to acknowledge this in subsequent reports.

Glossary of Terms

The Hospital Standardised Mortality Ratio (**HSMR**) - the case-mix adjusted mortality rate relative to the national average. It relates only to deaths in hospital.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. This metric relates to deaths in hospital and within 30 days of discharge. It is the principle NHS mortality metric for NHS trusts.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Quality and People Committee and Executive Committee**			
Title of Report	72-hour standards report and 7-day working report			
Date of Meeting	22nd September 2026	**Author**	Mark Roberts, Deputy Medical Director	
Executive Lead	Catherine Lissett Chief Medical Officer	**Executive Sign Off**	15th Sept 2026	
Governance Route				
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		X		
Executive Summary	The NHS England 72-hour standards describe the expected model of care for acutely unwell patients during the first 72 hours of hospital admission. The standards were published in December 2025 and are supported by a national self-assessment and board assurance framework intended to identify gaps, support improvement and provide oversight of implementation. **National guidance acknowledges that implementation is at an early stage and that many organisations are still developing the capability to measure compliance consistently.** This report provides TSDFT's assessment of its current position against the standards and outlines the actions being taken to improve compliance over time. The Trust has established strong governance arrangements through Executive Committee, Quality and People Committee, Internal Professional Standards for Urgent and Emergency Care, and implementation of the EPIC electronic patient record. These provide a robust platform for future improvement. The assessment identifies a number of areas of good progress, including operational policies and escalation processes, specialty decision-maker availability, standardised pathways, frailty services, and development of an integrated digital record through EPIC. As with many acute trusts nationally, the principal gaps relate to the availability of reliable performance metrics, workforce capacity to deliver full seven-day service standards, continuity of senior clinical review, support-service availability outside normal working hours, and measurement of compliance with several newly introduced standards. The current assurance ratings therefore reflect limitations in evidence and maturity of implementation rather than evidence of poor-quality care. Overall, the Trust making appropriate progress towards implementation of the Model Acute Pathway standards and has established the governance, culture and improvement infrastructure required to support further development over the next 12-24 months. **There is currently no nationally published benchmarking dataset against these standards and therefore assurance should be interpreted as an assessment of organisational maturity and evidence availability rather than comparative performance against peer organisations.**			
Recommendation	The Committee is asked to: • Note the current assessment against the NHS England 72-hour standards. • Recognise that these standards represent an emerging national improvement framework and maturity model rather than a performance-managed target. • Take assurance that appropriate governance, Internal Professional Standards, workforce planning and digital developments are in place to support continued implementation.			

Torbay and South Devon NHS Foundation Trust

	• Support ongoing work to improve data visibility, strengthen seven-day services where feasible, and maximise the benefits available through EPIC to support both patient care and performance improvement.					
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**
How this paper supports delivery of the Strategy	Supports safe and effective urgent and emergency care pathways through more consistent care, reduced variation, improved flow, stronger 7-day services and better use of EPIC data and functionality.					

Board Assurance					
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**		
Quality, Safety, Clinical Outcomes and Patient Experience	Quality, safety and patient experience; performance; people and culture; finance	16	Improved quality and consistency of care, improved performance, more sustainable working patterns and better use of financial resources.		
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	X		**X**		**X**
Compliance / Regulatory Requirements	NHS England guidance and standards for care of acutely unwell patients, published 16 December 2025; Trust Internal Professional Standards for urgent and emergency care.				
Ethical or EDI implications?	The source paper does not include a formal EDI assessment. It identifies equity of 7-day access and support for older people with frailty as relevant considerations.				

Assurance rating	Significant	Moderate	Limited	Inadequate
			X	
Assurance rationale	Whilst there is evidence of substantial progress in governance, policy development, pathway standardisation, frailty services, specialist decision-maker arrangements and digital enablement, the Trust cannot yet routinely evidence compliance with several standards due to limitations in available performance metrics and ongoing workforce constraints. This position is consistent with the early implementation phase of the national framework and does not necessarily indicate poor clinical performance. Continued development of EPIC reporting capability, Internal Professional Standards and seven-day service models is expected to strengthen assurance over time			
Appendices	None			

Torbay and South Devon NHS Foundation Trust

72-hour Standards and 7 Day working

1. Introduction and background

NHSE published its guidance and standards for care of acutely unwell patients on 16th December 2025. This guidance was created following 1.7 million patients spending greater than 12 hours in emergency departments in 2024. It is also widely understood that length of stay in hospitals is 10% greater than it was pre pandemic.

The guidance and standards published by NHSE outlines the approach for each acute provider to take during the first 72 hours of a patients stay within acute hospitals and when implemented these standards aim to

- reduce the time patients are spending in emergency departments
- reduce 12-hour waits and corridor care
- improve quality, safety and patient experience
- reduce anxiety and stress for carers and family members by improving information sharing and involvement in care planning
- ensure greater clarity, ownership and oversight of care
- help reduce unnecessary long stays in hospital and help people return to their homes more quickly

2. Purpose of report

This report is designed to inform QPC and Exec Co on the Trusts current performance in relation to these standards, and how we plan as an organisation to respond to meeting the standards set out nationally in relation to the first 72-hour period and the 7 day working approaches.

3. Commentary on Standards 1-13

Italics present the national standard, the TSDFT position is in non-italics.

Standard 1: initial and expert assessment

3.1 *All patients should have a full assessment by a competent clinical decision-maker within 1 hour of referral from the emergency department (ED) or of arrival on the acute receiving area.*

3.2 Torbay and South Devon Foundation Trust (TSDFT) position – we have built rotas with this grade of decision maker in our receiving and assessment areas but we do not currently know how often we meet this standard within 1 hour.

3.3 *Any time-critical medications should be identified and prescribed with a plan for a pharmacy review within 24 hours of admission. This should complement, not duplicate, any previous assessment.*

3.4 TSDFT position – our ED and assessment unit teams have an enhanced focus on prescribing time critical medications at the point time of first assessment. Time critical medications are now prescribed at first assessment where clinically relevant.

3.5 *EDs and acute receiving teams should work together to deliver and document a streamlined assessment that builds on a shared clinical narrative.*

3.6 TSDFT position – until April 2026, our ED and assessment teams shared the same documentation software in ED, but this switched to paper-based models outside of ED. EPIC has replaced this model effectively and delivered a more joined up, shared clinical narrative that can reduce duplication of effort.

3.7 *All admitted patients should be assessed by an expert clinical decisionmaker, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight.*

3.8 TSDFT position – we currently cannot measure how often we achieve this standard. In preparation of this report, I have been advised that EPIC One Devon colleagues are constructing a dashboard to meet this standard for the 3 acute providers and that we are not unique in this domain.

3.9 *Acute trusts should resource and plan the expert decision-maker workforce to maximise the day's work by modelling cover for peak times*

3.10 TSDFT position – we continually review whether evening and weekend arrangements, with predictable peak times, can be better resources with expert decision makers. We have 24/7 on-call support from expert decision makers, but planned on-site presence drops dramatically after 5 pm weekdays in in a less predictable manner at weekends and bank holidays. We have single expert decision makers with planned on-site presence until 8pm in some specialties and are scoping how we enhance this tier with additional equivalent decision makers with expansions in Same Day Emergency Care services.

Standard 2: additional requirements for specific patient cohorts

Older people with frailty

3.11 *Patients aged over 65 presenting to hospital as an emergency should be assessed by a competent clinical decisionmaker within 30 minutes of arrival using the Clinical Frailty Scale (CFS) and the 4AT tool for delirium.*

3.12 TSDFT position – we did not know our performance until April 2026's EPIC implementation programme. We now record between 40-50% eligible ED patients with Clinical Frailty Scores before they leave the ED environment but the time to achieving this is not being recorded at present. 4AT delirium tool tracking is materially more difficult to track with no current, reliable data.

3.13 *Acute trusts should ensure that older people with frailty (CFS 5+) have access to a senior clinical decisionmaker with skills in managing frailty and multiple long-term conditions within 1 hour of referral during the day, or before 10am the next day if overnight.*

3.14 TSDFT position – we have made significant improvements and investment in this area particularly with the Harbour Frailty team set up but workforce capacity constraints limit the extent to which we can aspire to this clinical standard. A review of specialty-based assessments, to improve access to specialists in frailty within the timescales recorded, is currently underway but results are not available for this report.

3.15 *All older people with frailty (CFS 5+) should be assessed by an expert clinical decisionmaker in managing frailty, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight.*

3.16 TSDFT position – our focus on 'Post Take Ward Round' by expert clinical decision makers skilled in frailty identification and management works towards meeting this standard. Automated recording of this will be achievable following dahsboard construction from the One Devon EPIC team.

3.17 *Specialty and/or specialist palliative care teams should be consulted when known patients present to ED with an exacerbation of a long-term condition, where appropriate.*

3.18 TSDFT position – the latest 3 months of manually held data reveals our specialist palliative care team review all patients in ED on the same day of referral, or within 4 hours of the next day. The data for other specialty consults is not currently available.

3.19 *Acute trusts should ensure patients who are receiving palliative care and end-of-life care or who have advance care plans can be identified to ensure their preferences and wishes are supported*.

3.20 TSDFT position – increased roll out of electronic Treatment Escalation Plans and its link to the EPIC system have enabled salient information to be more consistently available to influence and guide care.

Standard 3: operational policies

3.21 In line with national expectations, our operational policy at TSDFT is all patients by default move to our medical, surgical and paediatric assessment areas unless clear exceptions eg Acute Stroke, Cardiac emergency coronary catheterisation.

3.22 We have co-produced with specialties clear admission criteria and pathways for all commonly presenting clinical problems.

3.23 We have co-produced and published clear escalation and dispute resolution processes 24/7 as part of 2026 Internal Professional Standards work.

Standard 4: clinical leadership of patient flow

3.24 In line with national expectations pre-EPIC, outside ED, our assessment and ward areas had regular MDT meetings to update Swiftplus boards to promote the right patient moving to the right specialty bed. Since EPIC, teams request certain specialties if deemed that the patient should only go to that specialist area. In most cases the clinical site managers accommodate the clinical view and move patients to the most appropriate specialty bed.

3.25 *Acute trusts should have a designated consultant in charge who is responsible for the acute take, mirroring the EPIC role in ED and working with the nurse in charge and/or allocated navigation team to prioritise and co-ordinate patient care.*

3.26 TSDFT position - we have this in most specialties, though not all, notably General Internal Medicine.

3.27 We seek to access alternatives to admission, utilising our same day emergency care (SDEC) and virtual wards/hospital at home offers.

3.28 *The consultant in charge should not cover additional clinical duties such as downstream wards or outpatient care*.

3.29 TSDFT position – we currently lack the workforce capacity to enable a leadership role like this in any specialty which does not also have additional direct care clinical duties attached.

Standard 5: senior clinical decision-maker availability

3.30 *A senior clinical decision-maker or above in specialties with highest non-elective admission numbers/rates should be job planned/rostered to receive referrals and provide advice to primary and community care and hospitals 24/7.*

3.31 TSDFT position – we have senior decision makers (tier 2 group) onsite and available 24/7.

3.32 *Job planning/rostering may be networked across acute trusts where appropriate or required and should not negatively impact on the general internal medicine rota.*

3.33 TSDFT position – we are actively seeking to align to this expectation esp in certain vulnerable specialties such as hyperacute stroke care but without workforce expansion this is likely to negatively impact on general internal medicine rotas.

3.34 *If a senior clinical decision-maker or above performs this role, they should have immediate access to an expert clinical decision-maker.*

3.35 TSDFT position – we have 24/7 access to expert decision makers via on-call rotas at all times.

Standard 6: continuity of care

3.36 *Expert clinical decisionmakers in acute receiving areas with accountability for individual patients should be job planned and rostered to ensure continuity of care across the first 72 hours and reduce multiple consultant episodes*.

3.37 TSDFT position – many of our key receiving specialities such as Orthopaedics and General Surgery and Cardiology run a modified Consultant of the week model which meets this standard. Larger volume specialties like Acute Medicine require a shift model approach which makes meeting this standard for continuity more challenging.

Standard 7: ward rounds and board rounds

3.38 *All our inpatient and assessment units have a targeted, consultant-led and multidisciplinary team (MDT)-supported ward round during weekdays and weekends.*

3.39 TSDFT position – we meet this standard during weekdays but capacity constraints at present me we do not deliver a consistent model at weekends.

Standard 8: clinical huddles and handovers

3.40 Clinical huddles and shift handovers are led by an appropriate senior clinical decision-maker and take place at a designated time and place, with MDT participation from the relevant incoming and outgoing shifts in our ED, Assessment unit and inpatient wards.

3.41 In line with national expectations , we have a morning and night standardised handover for the Trust on-call resident teams that Consultants are invited to as needed. We use existing electronic handover tools for out of hours and weekend tasks.

Standard 9: specialty response times

3.42 *Where a patient requires urgent specialty opinion for acuity, clinical decision-making or discharge planning, the specialty senior clinical decision-maker should respond within a maximum of 2 hours of the request.*

3.43 TSDFT position – we do not currently measure how often senior clinical decision makers in this setting meet this standard. EPIC metrics which are time stamped will assist in this process but are in the process of being constructed as part of a regional programme of work.

3.44 *Patients referred to another specialty by the admitting team should be assessed by a senior clinical decision-maker (with access to an expert clinical decision-maker) within 4 hours during the extended day (as determined by demand and capacity modelling) or before 10am the next day if overnight.*

3.45 TSDFT position – we do not currently measure how often senior clinical decision makers in this setting meet this standard. Upcoming EPIC metrics which are time stamped will assist in this process.

Standard 10: bed transfers

3.46 *Patients requiring downstream specialty beds should be transferred within 12 hours of a bed request. If no bed is available, the specialty team should ensure daily review on the acute receiving area.*

3.47 TSDFT position – most downstream specialty teams have very limited capacity at present to attend acute receiving areas consistently.

3.48 *Specialty teams should know how many patients are waiting for a base ward bed at all times and work to deliver transfer within 12 hours of referral.*

3.49 TSDFT position - we currently do not routinely expect this of all teams but are moving towards specialties manage their own queues of acute patients that is less reliant on ED facilities.

3.50 At TSDFT we are aligned to the principle that patients should not usually move from downstream wards or ICU/ITU to acute receiving areas (reverse flow).

Standard 11: Length of Stay on Acute Receiving Areas

3.51 *Any individual patient's length of stay on an acute receiving area should not exceed 72 hours unless sanctioned by the responsible consultant and senior nurse in charge.*

3.52 TSDFT position – we aspire to this standard but the proportion of patients staying more than 72 hours in our acute receiving areas has grown by approximately 40% in since January 2026 and is likely related to a 20% increase in SWAST arrivals since late 2025 and a deterioration in pre-noon discharges from specialty wards especially since EPIC implementation.

Standard 12: availability of support services

3.53 *To ensure equity of provision of care and maximise discharge opportunities, all support services, including therapies, pharmacy and social services, should be available to acute receiving areas during extended-day working hours (for example, 8am to 8pm), 7 days a week.*

3.54 TSDFT position – Some key Allied Health services, including our discharging facilitating JETS team and Pharmacy, currently can not match this standard due to capacity constraints. At weekdays,

their service closes at 6pm, at weekends this is 4pm. Pharmacy opening hours at weekends are until 2 p.m..

3.55 *All areas providing acute and emergency non-elective care in the first 72 hours must have the same access to diagnostics, including imaging, in terms of availability and turnaround times, to support decision-making and prevent unnecessary admission.*

3.56 TSDFT position – we have timely access to plain, ultrasound and CT diagnostics to support this. MR services and cardiac imaging is more variable due to fluctuations in the extent of diagnostic backlog on site.

Standard 13: accurate recording of patient care

3.57 *Patients' care should be accurately attributed and recorded to the team delivering it.*

3.58 TSDFT position – EPIC records the primary specialty attending to patient care.

3.59 *If a patient is transferred from an acute receiving area to a specialty ward, the TFC should be changed to reflect the patient's responsible consultant.*

3.60 TSDFT position – EPIC enables ward and specialty staff to recode patient consultants appropriately.

Standard 14: patient and carer experience

We meet this standard with a focus on 'four patient questions' daily to track the patient experience, a focus on home-first and get up and dressed culture to counter deconditioning and improve independence and dignity.

Standard 15: compliance and governance

Our Emergency care pathways Internal Professional Standards went live 30 days after EPIC implementation with clear standards, conditions list and escalation processes to resolve disputes. We are setting up measures to track progress and have an in-person multiprofessional event in early October 2026 to discuss how we embed these successfully within the current opportunities and constraints.

4. Assurance recommendations and summary

The NHS England 72-hour standards represent a new national framework describing the expected model of care during the first 72 hours of an acute hospital admission. The standards are supported by a self-assessment and board assurance process intended to identify gaps, support improvement and monitor progress over time rather than provide a performance-managed assessment of compliance.

TSDFT has made significant progress in establishing the foundations required to implement the standards. These include implementation of the EPIC electronic patient record, development of Internal Professional Standards for Urgent and Emergency Care, strengthened frailty services, agreed specialty pathways and escalation processes, and established governance arrangements through Executive Committee and Quality and People Committee.

The principal challenges identified in this review relate to measurement capability, workforce capacity and seven-day service provision rather than the absence of improvement activity. In several domains,

reliable performance measures are not yet available locally and similar data limitations are being addressed across the wider One Devon system through development of shared EPIC reporting solutions.

Areas requiring particular focus include early senior review metrics, continuity of care measures, specialty response times, transfer performance, length of stay in receiving areas, pharmacy and therapy availability outside core working hours, and wider seven-day service capability.

Overall, the Trust is judged to be making appropriate progress towards implementation of the national Model Acute Pathway standards. The current Limited Assurance rating reflects the early maturity of measurement systems and implementation programmes, rather than evidence of poor-quality care or lack of organisational commitment to the standards. Continued development of EPIC reporting, Internal Professional Standards and workforce models is expected to strengthen assurance over the next reporting cycles

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Early clinical decision-making	Limited	Unchanged
Early clinical decision-making Frailty	Limited	Unchanged
Care navigation Operational policies, pathways and escalation	Satisfactory	Improved
Care navigation Clinically led flow	Limited	Unchanged
Care navigation Specialty decision maker availability	Satisfactory	Unchanged
Care on the acute receiving area and continuity of care Continuity and minimising handover	Limited	New
Care on the acute receiving area Boardrounds and outlying patients	Limited	Unchanged
Care on the acute receiving area Senior-led standardised handovers/huddles with MDT participation	Satisfactory	New
Care on the acute receiving area Timeliness of urgent specialty opinion delivery	Limited	New
Care on the acute receiving area Transfer targets and flow direction	Limited	New
Care on the acute receiving area Low length of stay targets	Limited	Unchanged
Support services and 7-day working Diagnostic and support service availability	Limited	Unchanged

Data recording and metrics 13, Accurate attribution/coding (e.g., TFC 326 for acute medicine first episode)	Limited	New
Our patients, families and carers Patient and family involvement and goal setting	Limited	New
Board assurance Internal Professional Standards and performance progress	Limited.	Improved

Public Board Workplan

			2026/27			2027/28					
AGENDA ITEMS	**FREQUENCY**	**AUTHOR**	**Nov-27**	**Jan-28**	**Mar-28**	**May-28**	**Jul-28**	**Sep-28**	**Nov-28**	**Jan-29**	**Mar-29**
PRELIMINARY MATTERS (ALL MEETINGS)											
Welcome, Apologies, Declarations and Quoracy	All meetings		X	X	X	X	X	X	X	X	X
STANDING ITEMS											
Minutes , actions and matters arising	All meetings		X	X	X	X	X	X	X	X	X
Chair's Briefing	All meetings	Chair	X	X	X	X	X	X	X	X	X
Chief Executive's Briefing	All meetings	CX	X	X	X	X	X	X	X	X	X
BAF/CRR	All meetings	ADCG	X	X	X	X	X	X	X	X	X
FOR APPROVAL											
Winter Plan		COO	X						X		
FOR REVIEW											
Patient Story	All meetings	CNO	X	X	X	X	X	X	X	X	X
Our Plan for Better Care	All meetings	CSPO	X	X	X	X	X	X	X	X	X
Tower Update	As required	CX	X								
REPORTS FROM BOARD SUB COMMITTEES, CHARITY AND SUBSIDIARIES											
Audit and Risk Committee											
Charity Committee											
Charity Committee Annual Report and Video		Comms		X						X	
Finance and Performance Committee											
Operational Performance	All meetings	COO	X	X	X	X	X	X	X	X	X
Monthly Finance Report	All meetings	CFO	X	X	X	X	X	X	X	X	X
EPR Status	Quarterly	COO									
SHD Developments Annual Report	Annual	CFO	X						X		
Quality and People Committee											
Perinatal Quality and Safety Report	Quarterly	CNO	X		X	X		X	X		X
Maternity Staffing Bi-Annual Report	Bi-annual	CNO	X			X			X		
NHSE Safer Staffing Report	Bi-annual	CNO			X			X			X
Children Safeguarding Annual Report	Annual	CNO	X								
Health Inequalities	Annual	CNO				X			X		
Adult Safeguarding Annual Report	Annual	CNO	X								
Patient Experience Annual Report	Annual	CNO	X								
Mortality Scorecard/Learning from Deaths	All meetings	CMO	X	X	X	X	X	X	X	X	X
Working Lives of Resident Doctors	Quarterly	CMO			X	X		X	X		X
7 Hour Standards and 7 Day Working		CMO				X			X		
Annual Revalidation Report	Annual	CMO						X			X
WRES/WDES	Annual	CPO				X			X		
Delivery of People Strategy Quarterly Update	Quarterly	CPO		X		X	X		X	X	
CONSENT ITEMS											
Review of Directors' Interests		ADCG				X					
CLOSING MATTERS											
Review of meeting	All meetings		X	X	X	X	X	X	X	X	X
BAF (matters for review or escalation)	All meetings		X	X	X	X	X	X	X	X	X
Review Workplan	All meetings		X	X	X	X	X	X	X	X	X
Matters for escalation	All meetings		X	X	X	X	X	X	X	X	X
Any other business	All meetings		X	X	X	X	X	X	X	X	X
Date of next meeting	All meetings		X	X	X	X	X	X	X	X	X
OTHER ITEMS											
Thirwall Report		CNO	X								
Torbay Council Public Health Annual Report - Lincoln Sargeant to attend		CX		X							
NHSE Monitoring of R&D		CMO	X								
FUTURE ITEMS											
ITEMS FOR INFORMATION											
IPQR	All meetings	COO	X	X	X	X	X	X	X	X	X
Cultural Insights Report	All meetings	CPO	X	X	X	X	X	X	X	X	X
Freedom to Speak Up Bi-Annual Report	Bi-annual	CPO	X			X			X		
R&D Annual Report	Annual	CMO		X							
Pay Gap	Annual	CPO			X						
Clinical Audit Forward Plan	Annual	CNO					X			X	
National Maternity Triage Specification	Annual	CNO	X								
Patient Safety Incidents Annual Report	Annual	CNO		X							
CQC Maternity Inpatient Survey	Annual	CNO			X						
Medicines Optimisation Annual Report	Annual	CMO					X			X	
Review of CNST Compliance	Annual	CNO	X								
CQC National Inpatient Survey	Annual	CNO		X							

Public Board Workplan

			2026/27			2027/28					
AGENDA ITEMS	FREQUENCY	AUTHOR	Nov-27	Jan-28	Mar-28	May-28	Jul-28	Sep-28	Nov-28	Jan-29	Mar-29
Maternity Incentive Scheme	Annual	CNO			X						
2025 National Staff Survey	Annual	CPO				X			X		
End of Life Annual Report	Annual	CMO					X			X	

Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors -
Items for Information

Date: Thursday 5 November 2026

Time: 12.30 pm - 3.00 pm

The Boardroom, Hengrave House,
Torbay Hospital

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Working with you, for you

TSDFT Public Board of Directors - Information Pack

Board Room, Hengrave House

Torbay and South Devon NHS Foundation Trust

05/11/2026 12:30 - 15:00

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NHS
Torbay and South Devon
NHS Foundation Trust

Our winter plan to support the people of Torbay and South Devon to live well



Winter Plan

2026/27

Executive Summary

Torbay and South Devon NHS Foundation Trust's Winter Plan 2026/27 sets out a clinically led response to sustained urgent and emergency care pressure from October 2026 to March 2027. Its objectives are to provide safe, timely and equitable care; reduce corridor care, ambulance handover delays, avoidable admissions and length of stay; and protect elective and specialist services wherever possible.

The plan responds to high Emergency Department demand, continued high bed occupancy, extended waits, delayed discharge and seasonal respiratory and infection surges. Essential estates works will further constrain acute capacity, making reliable admission avoidance, patient flow and discharge essential.

Delivery will be overseen by the Winter Planning Group, with executive accountability through the Chief Operating Officer and reporting to the Executive Committee. Performance will be monitored through daily Safety and Flow meetings, care-group governance and system coordination, using measures including corridor care, handover delays, 12-hour waits, occupancy, discharge, length of stay, workforce, infection and elective delivery.

The Equality and Quality Impact Assessment identifies overall benefits for safety, experience and equity, with mitigations for people affected by disability, communication, digital, transport, rurality or deprivation barriers.

Key risks are demanding exceeding forecast, delayed mobilisation, workforce and infection pressures, constrained beds and discharge capacity, financial pressure, adverse weather or industrial action, and impact on elective care.

Easy Read Summary

Our aim: to give people safe, timely and fair care throughout winter, reduce delays and corridor care, and protect planned services wherever possible.

Why we need a winter plan

Winter brings increased demand, respiratory illness and infection outbreaks, pressure on beds and staff, and more people waiting to leave hospital with social care. Essential estates work will also reduce some acute bed capacity. We therefore need to avoid unnecessary admissions, improve flow and help people return home safely as soon as they are ready**.**

Our four priorities

Right Care: early senior review and the right clinical decision first time.

Right Pathway: Non-Admitted Pathways within the ED footprint, Same Day Emergency Care, HOT clinics, frailty services, virtual wards, community diagnostics and Urgent Community Response where appropriate.

Right Flow: start discharge planning early, use Home First and Discharge to Assess, book transport in advance and reduce avoidable delays and length of stay.

Right Coordination: use clear escalation routes, seven-day leadership and daily Safety and Flow oversight.

What will be different this winter

- More patients will be assessed and treated without being admitted to hospital.
- Frailty, community and virtual services will support more people closer to home.
- Discharge planning will begin earlier, with increased focus on seven-day discharge and reducing long stays.
- Ambulance handovers, 12-hour waits, corridor care and bed occupancy will receive close operational oversight.
- Elective, cancer, maternity, paediatric and diagnostic services will be protected wherever it is safe to do so.
- Vaccination, infection prevention, safe staffing, staff wellbeing and tested emergency arrangements will support resilience.

What staff need to do

- Use the right pathway first time and seek early senior advice.
- Start discharge planning on admission and identify barriers promptly.
- Escalate safety, staffing, flow and infection concerns early.
- Keep patients, carers and colleagues informed using accessible communication and reasonable adjustments.
- Follow infection-prevention advice, take up vaccination when eligible, take breaks and seek wellbeing support early.

When pressure increases

Follow the current Operational Surge, Flow and Escalation Policy and local OPEL actions. Safety and Flow meetings take place at 08:45, 12:00, 15:30, 20:00 and 22:00, with extra meetings arranged when needed. Outside core hours, concerns should be escalated through the Clinical Site Manager, On-Call Manager and Director on Call as appropriate.

How we will know the plan is working

We will monitor corridor-care episodes, ambulance handover delays, Emergency Department waits, bed occupancy, discharge timing, length of stay, community response, workforce availability, vaccination uptake, infection outbreaks and the effect on planned care. Actions and risks will be reviewed through daily operational oversight, Care Group governance, the Winter Planning Group and the Executive Committee.

Acronym Buster

Acronym	Meaning
ADNPP	Associate Director of Nursing and Professional Practice
AMU	Acute Medical Unit
ARI	Acute respiratory infection
COPD	Chronic obstructive pulmonary disease
D2A	Discharge to assess
DCC	Devon County Council
DCCPAs	Direct clinical care programmed activities
DIPC	Director of Infection, Prevention & Control
ED	Emergency Department
ENT	Ear, Nose & Throat
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERF	Elective recovery fund
G&A	General & acute
G&G	Grounds & gardens
HCAI's	Healthcare associated infections
IA	Industrial Action
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive care unit
IMT	Incident Management Team
IPC	Infection Prevention Control
IV	Intravenous
LoS	Length of stay
MAAT	Medical admissions avoidance team
OOH	Out of hours
OP	Outpatient
OPAT	Outpatient parenteral antimicrobial therapy
OPEL	Operational pressure escalation levels
OT	Occupational therapist
PAC	Patient Access Centre
POCT	Point of care testing
RSU	Respiratory support unit
RSV	Respiratory syncytial virus
RTT	Referral to treatment
SDEC	Same day emergency care
SOP	Standard operating procedure
SQAG	Safety Quality Assurance Group
SRU	Surgical Receiving Unit
SWAST	South Western Ambulance Service Trust
TSDFT	Torbay & South Devon NHS Foundation Trust
UCR	Urgent community response
UEC	Urgent & Emergency Care
UTC	Urgent Treatment Centre
VW	Virtual ward
WLI	Waiting list initiative

Winter Plan 2026-27

Context

This paper outlines the approach to the development and operationalisation of the 2026/2027 winter plan for Torbay and South Devon NHS Foundation Trust.

Last winter delivered the strongest urgent and emergency care performance in three years nationally, despite early flu circulation, norovirus peaks and industrial action. NHS England has been clear that this improvement was driven by early, clinically led, collaborative planning, and the expectation for 2026/27 is that Trusts and systems build on this foundation with even greater rigour, pace and whole-system coordination.

For 2026/27, every Trust must produce a robust, clinically led and deliverable organisational winter plan, aligned with the wider system plan and signed off by the Trust Board using the national Board Assurance Statements (BAS). Draft plans must be completed by end of August 2026, with regional stress-testing exercises taking place in September and final BAS submissions required by 30 September 2026.

National Priorities and Expectations for Winter 2026/27

This year's national approach is framed through the Model ICB and Model Region Blueprints, clarifying that:

- ICBs commission capacity and lead prevention, vaccination and system coordination.
- Providers deliver operational performance, resilience and safe care.
- Regions oversee assurance, stress testing and mutual aid.

The Trust winter plan must demonstrate how our organisational actions support the ICB's whole-area demand and capacity modelling, surge planning and commissioned capacity across primary, community, mental health and social care.

While NHSE has not reissued the seven UEC priorities in the same format as 2025/26, the expectations for providers remain tightly focused on flow, discharge, ambulance interface, vaccination, Infection, Prevention and Control (IPC) and elimination of corridor care.

System Requirements for 2026/27

System winter plans must demonstrate:

- improved vaccination uptake, particularly in children and high-risk groups
- increased care delivered in primary, community and mental health settings
- achievement of the maximum 45-minute ambulance handover standard
- improved hospital flow, with a focus on reducing 12-hour waits and eliminating corridor care

- clear local performance targets for discharge pathways, including eliminating internal delays >48 hours
- sufficient intermediate care and social care capacity commissioned jointly with local authorities
- tested surge and extreme surge arrangements across all partners

The Trust plan must align directly with these system requirements and demonstrate our organisational contribution to each.

Local Case for Change

In May 2026, Torbay and South Devon NHS Foundation Trust recorded 7,154 ED attendances, 2,556 ambulance handovers and 839 patients who spent more than 12 hours in ED. Bed occupancy was 94.2%, average length of stay had increased to 9.76 days and only 12.5% of discharges occurred before midday. Around 70 patients each day were medically ready to leave hospital because of discharge delays. During the month, 1,014 patients experienced corridor care. Analysis demonstrated that corridor care was driven not only by demand, but by delays in flow and discharge across the whole patient pathway.

Roles and Responsibilities for Acute Trusts (NHSE 2026/27)

NHSE has defined a set of provider responsibilities that must be reflected in the Trust winter plan. The table below summarises the Trust response and where each requirement is addressed.

Responsibility	Trust requirement / planned response	Where covered in the plan
Vaccination and prevention	Improve vaccination uptake among health and care workers and provide an accessible occupational health offer throughout the flu campaign, including onsite bookable and walk-in appointments.	Pages 50–55: Winter Vaccination Programme 2026/27, staff offer, campaign delivery, communications and governance.
Ambulance interface	Deliver an improvement trajectory towards 15-minute hospital handovers, with no handover exceeding 45 minutes. Work with ambulance partners to maximise hear-and-treat, see-and-treat and referral to alternatives to ED.	Pages 26–31 and 41–46: Eliminating Corridor Care Programme, Medicine and UEC priorities, admission avoidance, system coordination and Operational

		Surge, Flow and Escalation.
Urgent and emergency care	Implement the Model Emergency Department, Model Acute Pathway and Model Discharge Pathway ahead of winter; eliminate corridor care; and use UTCs, paediatric urgent care pathways and children's standards effectively to improve four-hour performance.	Pages 26–31 and 35–37: Eliminating Corridor Care Programme, Unscheduled Care Village, co-located UTC, SDEC and paediatric urgent care model.
Flow and discharge	Set and profile daily Pathway 0 discharge targets; set and deliver targets for Pathways 1, 2 and 3; review bed use; maximise home-based care; provide surge capacity; and use IPC cohorting where appropriate.	Pages 15–18, 38–43 and 45–46: discharge performance, Community Plan, discharge hub and D2A, Home First, pre-Christmas occupancy reduction, discharge coordination and surge arrangements.
Operational resilience	Complete a clinically led organisational winter plan by the end of August; ensure tested escalation, IPC, on-call leadership and staff welfare arrangements; protect elective capacity; and contribute to system demand and capacity modelling and the ICB's seven-day coordination arrangements.	Pages 8–16, 20–25, 31–35 and 41–72: governance, demand modelling, Planned Care priorities, emergency preparedness, site leadership, system coordination, workforce resilience, IPC, staff wellbeing and risk management.

Winter Planning Governance and Responsible Individuals

To support the creation and delivery of the Torbay and South Devon NHS Foundation Trust Winter Plan for 2026/27, a Winter Planning Group has been convened. The process was launched on 1st July 2026. This group brings together medical, nursing and operational leads from each care group, alongside leads from key corporate and non-clinical areas of the Trust. Each member has been identified not only for their subject-matter expertise, but for their responsibility in supporting both the planning and operational delivery of the winter arrangements within their respective areas.

The group is chaired by the Acting Head of Operations/Head of Site Operations and provides a structured forum through which a clear, locally owned plan is developed. This ensures that every element of the winter plan is shaped by the staff who will enact it, with responsible individuals directly contributing to the design, testing and implementation of the actions required for winter resilience. Aligned to the NHS England Winter planning 2026/27 – expectations and assurance framework.

The Winter Planning Group has enabled:

- robust check and challenge of proposals to ensure plans are realistic, clinically led and operationally deliverable
- early identification of risks, conflicts or interdependencies between care groups and corporate functions
- effective idea generation and innovation, drawing on expertise from across the Trust
- clear accountability, with each member responsible for progressing actions within their area and ensuring readiness for winter delivery

The group reports directly to the Executive Committee, ensuring executive oversight of all elements of the plan and providing a clear governance route for escalation, assurance and decision-making. This structure ensures that responsible individuals are not only involved in planning but are actively accountable for supporting delivery throughout the winter period.

The membership of the Winter Planning Group can be seen below.

Area Covered	Responsible Individual
Executive Winter Lead	Sam Wadham-Sharpe
Medical Lead:	Mark Roberts
Nursing and AHP Lead:	Natalie Herring
Operational Lead	Craig Owen
Care Group Directors	Lee Johns, Shelly Machin, Kenny Naughton

Medicine/UEC Ops Lead	Lesley Wade, Lynn Towers
Surgical Ops Lead	Derren Westacott
Cancer and Clinical Support Services Ops Lead	Ria McCoy
W&C Ops Lead	Sarah Hughes
Community Lead	Sarah Bradley and Natalie Keens
Medicine/UEC Clinical Lead	Catherine Blakemore and Rachel Winfield
Planned Care Clinical Lead	Stuart Andrews and Lesley Archer
Families and Community Clinical Lead	Yahya Mubashar, Kath Bhatt & Jonny Hacon
Medicine Nursing Lead	Stephen Heath
Planned Care Nursing Lead	Sharon Boyne
Families and Community Nursing Lead	Paul Highton
AHP Lead	Denise Walker/Lisa Baker
Vaccination Lead	Natalie Herring
IPC Lead	Tracey McKenize
People Lead	Laura Fuller
Estates and Facilities Lead	Tony Hopkins
EPRR Lead	Sam Biden
Communications Lead	Jane Harris/Laura Patrick
Improvement lead	Carly Renaud
ICB Locality Lead	System coordination leads

*Each designated lead is responsible for ensuring a suitable deputy is identified and briefed to provide cover during periods of leave, absence or unavailability.

Governance

Executive Lead:
Sam Wadham-Sharpe - Chief Operating Officer
Medical Lead:
Mark Roberts – Deputy Medical Director
Nursing and AHP Lead:
Natalie Herring – Deputy Chief Nurse
Operational Lead:

Craig Owen – Acting Head of Operations/Head of Site Operations

- The Trust Executive Committee has overall responsibility and oversight of the Winter Plan, with the Trust Executive Board providing strategic direction, assurance and support to ensure the plan is fully implemented and delivered.
- The Trust winter plan addresses the national Board Assurance Statement requirements for 2026/27, including governance, clinically led planning, winter demand modelling, ambulance interface, discharge improvement, corridor care reduction, vaccination, IPC, workforce resilience, escalation arrangements and system alignment. The plan identifies both internal Trust mitigations and system dependencies required to support safe care and operational flow during winter.
- The Head of Operations retains responsibility for version control, governance and maintenance of the Winter Plan, ensuring updates are made consistently and that all changes reflect operational requirements and executive decisions.
- Once approved by the Trust's Board of Directors, the Winter Plan will be disseminated to the Trust Executive Team, on-Call leadership, Care Group Directors and the Site Management Office. The approved plan will also be made accessible to all staff via the Trust's intranet to support organisation-wide awareness and operational readiness.
- In addition, the plan will be shared with partner organisations across the local health and care system, including NHS Devon ICB, to ensure alignment, transparency and coordinated delivery.
- Care Group Directors are responsible for communicating the winter plan within their areas and ensuring adherence to the actions, standards and expectations. They are accountable for supporting both the planning and operational delivery of winter arrangements within their services.

Equality and Quality Impact Assessment (EQIA)

An Equality and Quality Impact Assessment (EQIA) has been completed as part of the development of the Winter Plan 2026/27. (Appendix 1) The assessment considered the potential impact of planned winter interventions on patients, carers, staff and local communities, with particular consideration given to protected characteristics under the Equality Act 2010, health inequalities, access to services, digital exclusion, rurality, deprivation and vulnerable populations. The EQIA went to the Trust EQI panel on 10th September 2026.Feedback was provided and updates made to risk scoring following report.

The EQIA identified no significant adverse impacts arising from the implementation of the winter plan. The Winter Plan is expected to deliver positive quality and population-health benefits, but potential negative and differential impacts remain. Where risks were identified, mitigating actions have been incorporated into operational delivery plans and service redesign proposals. The EQIA has informed the development of the winter plan and will continue to be

reviewed throughout the winter period should material changes to services be required.

The Trust Board has reviewed the EQIA alongside the Winter Plan and is assured that equality, quality and patient safety considerations have informed the development of the plan.

Learning from Winter 2025/26

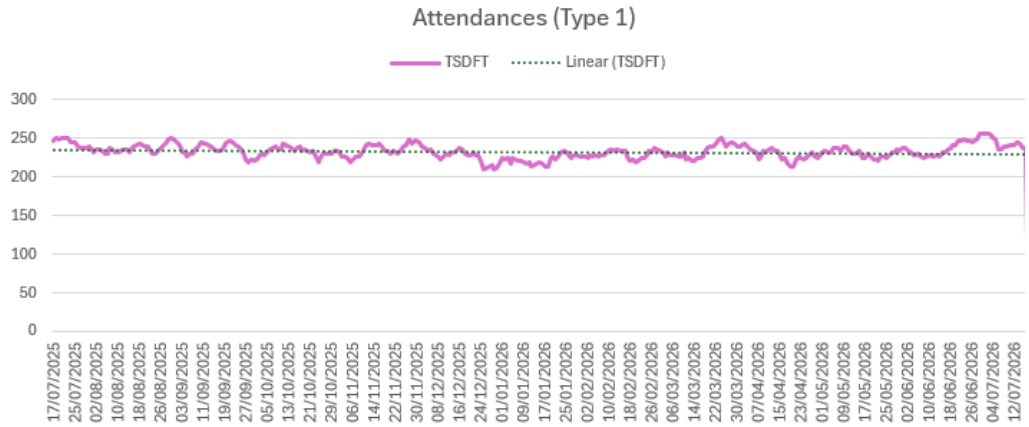
The Trust operated predominantly at OPEL 3, reflecting sustained system pressure and the need for enhanced operational management to maintain patient flow and safety. There were intermittent periods of escalation to OPEL 4, particularly during early October, mid-November, and towards the end of March, indicating short-lived episodes of severe pressure requiring whole-system response and executive oversight. Conversely, there were only a small number of days where the organisation de-escalated to OPEL 2, predominantly during brief periods in November and over the Christmas period. Overall, the pattern demonstrates that while the Trust experienced relatively stable demand through much of the winter, system capacity remained under consistent strain, necessitating sustained coordination across urgent and emergency care pathways, proactive escalation management, and close working with community and system partners to maintain patient flow and quality of care.

In preparation for the EPR go-live in April, the Trust undertook a whole-organisation training programme to support operational readiness and safe implementation. This required significant engagement from clinical, operational and corporate teams, with staff across the organisation completing role-specific training, familiarisation sessions and readiness activities ahead of launch. This created a significant but necessary workforce challenge, as staff were required to complete training alongside maintaining safe day-to-day service delivery, managing operational pressures and supporting patient care. The scale of the programme required careful coordination of rotas, protected training time and prioritisation of activity, with some non-essential meetings and activities needing to be reduced or stood down to release capacity.

Type 1 Attendances

Chart 1 below shows how the average daily number of Type 1 Emergency Department attendances varied throughout 2025/26 for the Trust. Across the year, attendances remained broadly stable at around **235–245 per day**, with minor month-to-month variation. There is no clear winter-specific surge, with demand remaining consistently steady throughout the year.

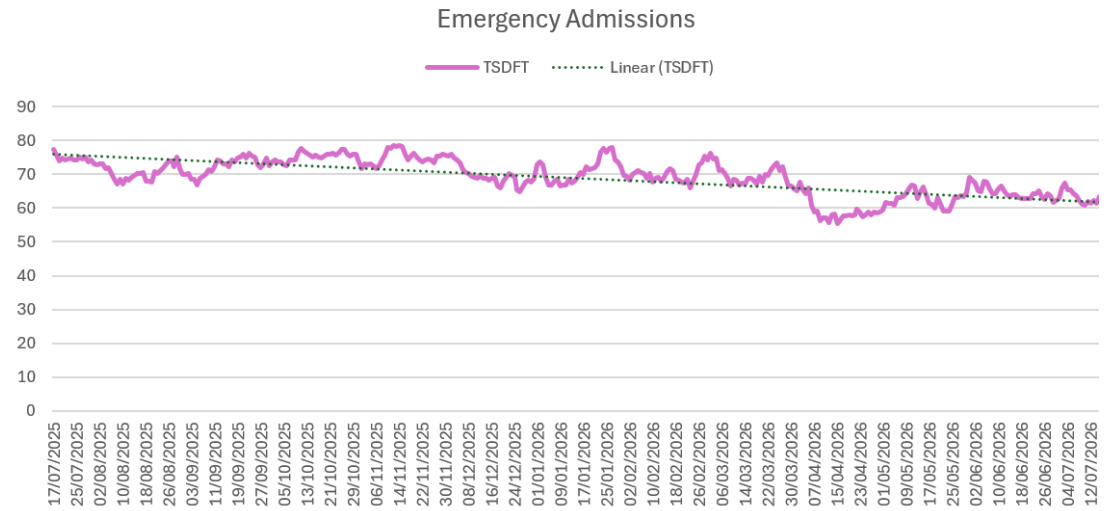
Chart 1 - Type 1 Attendances 17.07.2026 – 12/07.2026



Emergency Admissions

During the core winter period from October 2025 to March 2026, emergency admissions demonstrated normal daily variation but did not show a sustained winter escalation. Activity was highest during October and early November, generally operating in the mid-70s, before reducing through December and fluctuating across January and February. By March, admissions were more consistently in the mid-to-high 60s.

Chart 2 – Emergency Admissions 17.07.2026 – 12/07.2026



Admissions - Respiratory Conditions

Chart 3 – Average Daily Attendances (Type 1) April 2025/ March 2026

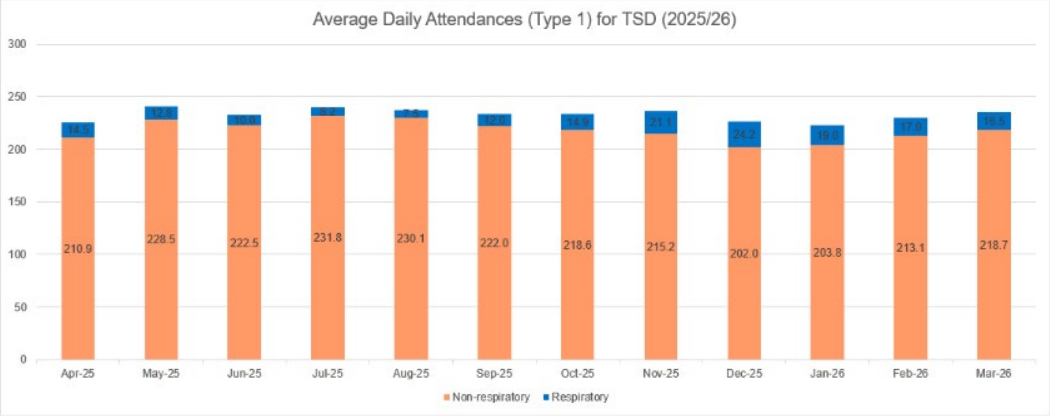
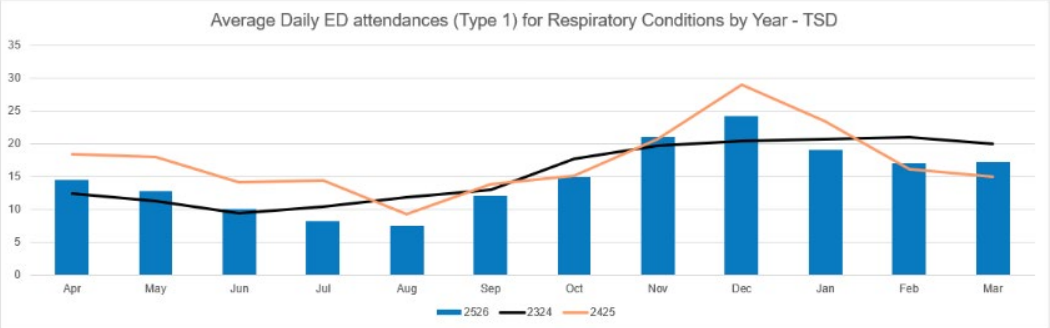


Chart 4 – Average Daily ED Attendances (Type 1) for Respiratory Conditions April 2025/ March 2026

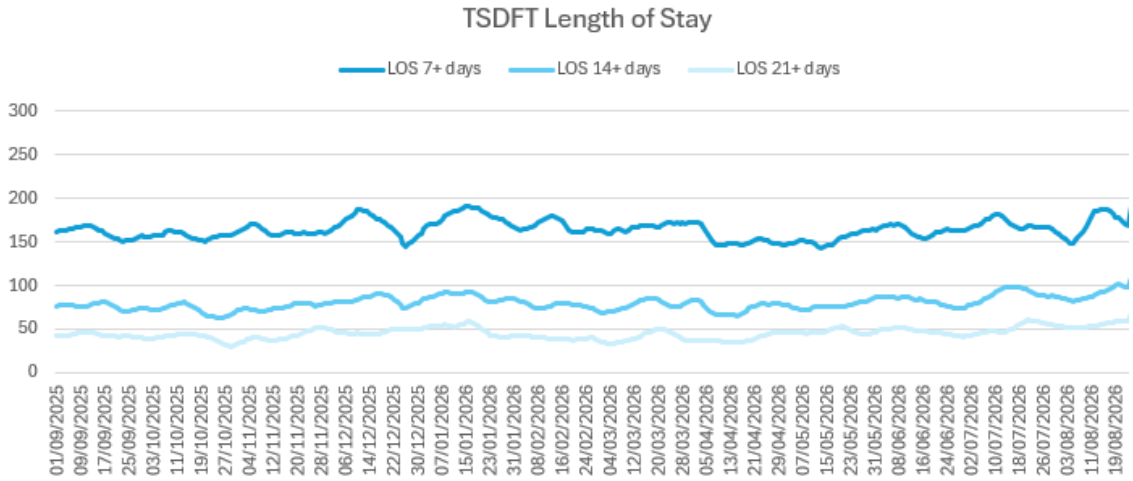


- The metric shows numbers of attendances at emergency departments by people diagnosed with acute respiratory infections and reported via NHS England Emergency Care Data Set (ECDS)

ED demand remains broadly stable throughout the year, with a predictable seasonal uplift that consistently peaks in December. Non-respiratory activity is steady and reliable, so winter escalation efforts should prioritise respiratory pathways. Although respiratory volumes fluctuate year-to-year, the seasonal pattern is highly consistent.

Length of Stay

Chart 5 – Length of stay from 1st September 2025 to 19th August 2026



The 2025/26 length of stay demonstrates a sustained long-stay challenge rather than a discrete winter surge. While the number of patients staying seven days or more fluctuated, the 14-day and 21-day cohorts increased across December 2025 and January 2026.

Discharge Performance and Discharge Pathways (1 October 2025 – 31 March 2026)

Chart 6 – Acute ward discharges by ward, discharge pathway, day and time. (1 October 2025 – 31 March 2026)

Ward Name	Total	Discharges	Transfers to a Community Hospital	Transfers to the Discharge Lounge	Deaths	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Average LoS (Days)	# Pre Noon	% Pre Noon	# Pre 5pm	% Pre 5pm	# Weekday	% Weekday	# Weekend	% Weekend
ACUTE MEDICAL UNIT	1,968	1,233	37	650	48	1,818	0	150	0	1.41	606	30.8%	1,528	77.6%	1,487	75.6%	481	24.4%
AINSLIE	470	220	37	198	15	317	34	106	13	8.53	94	20.0%	313	66.6%	400	85.1%	70	14.9%
ALLERTON	756	591	11	131	23	700	17	30	9	7.72	83	11.0%	477	63.1%	601	79.5%	155	20.5%
CHEETHAM HILL	560	234	26	244	56	225	124	135	76	10.61	178	31.8%	410	73.2%	483	86.3%	77	13.8%
CHEST PAIN UNIT	219	216	0	2	1	217	2	0	0	5.18	17	7.8%	163	74.4%	184	84.0%	35	16.0%
CORONARY CARE	228	219	0	3	6	224	1	3	0	3.64	15	6.6%	178	78.1%	194	85.1%	34	14.9%
CROMIE	966	748	20	172	26	870	39	54	3	5.34	180	18.6%	678	70.2%	759	78.6%	206	21.3%
DUNLOP	491	383	12	74	22	389	60	34	8	10.97	92	18.7%	362	73.7%	429	87.4%	62	12.6%
EAU4	1,403	921	33	383	66	1,151	77	171	4	1.71	209	14.9%	897	63.9%	1,158	82.5%	245	17.5%
ELLA ROWCROFT	641	552	22	63	4	526	30	78	7	5.72	117	18.3%	430	67.1%	479	74.7%	162	25.3%
FORREST	672	316	19	299	38	350	124	171	27	9.17	130	19.3%	434	64.6%	584	86.9%	88	13.1%
GEORGE EARLE	751	476	83	147	45	394	136	200	21	6.84	112	14.9%	452	60.2%	663	88.3%	88	11.7%
MCCALLUM	1,168	548	35	576	9	873	136	151	8	3.36	234	20.0%	793	67.9%	1,007	86.2%	161	13.8%
MIDGLEY	654	401	18	162	73	515	49	86	4	7.97	174	26.6%	483	73.9%	552	84.4%	102	15.6%
SIMPSON	462	151	19	244	48	223	73	140	26	12.21	114	24.7%	309	66.9%	388	84.0%	74	16.0%
TURNER	434	369	11	25	29	342	55	35	2	8.41	51	11.8%	258	59.4%	355	81.8%	79	18.2%
WARRINGTON	851	654	10	180	7	814	13	19	5	3.62	187	22.0%	654	76.9%	661	77.7%	190	22.3%
	12,694	**8,232**	**393**	**3,553**	**516**	**9,948**	**970**	**1,563**	**213**	**5.51**	**2,593**	**20.4%**	**8,819**	**69.5%**	**10,384**	**81.8%**	**2,309**	**18.2%**

Across the winter period the acute hospital achieved 12,694 adult discharges or transfers. Discharge activity remained predominantly weekday-focused, with 10,384 episodes (81.8%) occurring Monday to Friday and 2,309 (18.2%) taking place at weekends.

The discharge pathways highlight that the majority of patients (9,948; 78.4%) were discharged via Pathway 0, requiring no new health or social care support following discharge. A further 970 patients (7.6%) were discharged on Pathway 1, 1,563 patients (12.3%) on Pathway 2, and 213 patients (1.7%) on Pathway 3. The Pathway 2 cohort includes patients transferred to community hospitals.

Performance against discharge timeliness metrics demonstrates that 2,593 discharges (20.4%) were completed before midday, while 8,819 discharges (69.5%) occurred before 5pm.

Chart 7 – Community Hospital wards discharges by ward, discharge pathway, day and time. (1 October 2025 – 31 March 2026)

Ward Name	Total	Discharges	Transfers to a Community Hospital	Transfers to the Discharge Lounge	Deaths	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Average LoS (Days)	# Pre Noon	% Pre Noon	# Pre 5pm	% Pre 5pm	# Weekday	% Weekday	# Weekend	% Weekend
BRIXHAM	245	240	0	0	5	15	144	83	3	22.68	95	38.8%	206	84.1%	222	90.6%	23	9.4%
DART	196	193	0	0	3	9	120	62	5	24.01	96	49.0%	176	89.8%	164	83.7%	32	16.3%
DAWLISH	252	246	0	0	6	29	126	84	13	19.51	143	56.7%	226	89.7%	220	87.3%	32	12.7%
TEIGN WARD	351	332	0	0	19	44	223	73	11	23.51	161	45.9%	316	90.0%	305	86.9%	46	13.1%
TEMPLAR WARD	306	300	0	0	6	25	154	109	18	26.48	145	47.4%	273	89.2%	272	88.9%	34	11.1%
	1,350	**1,311**	**0**	**0**	**39**	**122**	**767**	**411**	**50**	**23.36**	**640**	**47.4%**	**1,197**	**88.7%**	**1,183**	**87.6%**	**167**	**12.4%**

Our Community Hospitals achieved 1,350 patient episodes. Discharge activity remained predominantly weekday-focused, with 1,183 episodes (87.6%) occurring Monday to Friday and 167 episodes (12.4%) taking place at weekends.

The discharge pathway profile reflects the role of Community Hospitals in supporting rehabilitation, recovery and discharge-to-assess services. The majority of patients were discharged via Pathway 1 (767 patients; 56.8%), with a further 411 patients (30.4%) discharged on Pathway 2, 122 patients (9.0%) on Pathway 0, and 50 patients (3.7%) on Pathway 3. This demonstrates the significant proportion of patients requiring ongoing care and support following an inpatient stay.

Performance against discharge timeliness metrics was strong, with 640 discharges (47.4%) completed before midday and 1,197 discharges (88.7%) completed before 5pm. Both measures exceeded the locally agreed targets of 33% pre-noon and 75% pre-5pm, demonstrating effective discharge planning and timely patient flow from Community Hospital wards.

Formal Debrief

A formal debrief was held on 14 July 2026, bringing together representatives from departments and services across the Trust. The learning is summarised below and has informed the priorities for winter planning and operational resilience.

Subject / area	What worked well	What did not work well	What will be different
Operational leadership	Seven-day Head of Site Operations	The SPoC role sometimes	Retain enhanced seven-day senior site

and escalation	cover improved oversight and responsiveness and significantly reduced pressure on the Manager on-call. The organisation also maintained continuity during Epic implementation and multiple periods of industrial action.	duplicated other functions.	leadership; clarify escalation thresholds, decision rights and named accountabilities; review and streamline the SPoC function.
Front-door clinical cover and admission avoidance	Paediatric pressures were more manageable through improved joint working. The UEC improvement plan, The Harbour at Newton Abbot Hospital and the cardiology virtual ward strengthened alternatives to admission.	Planned increases in resident doctor and consultant numbers were not achieved. Senior cover at the front door was often reactive and could adversely affect AMU, EAU4 and radiology activity.	Plan consultant and resident doctor capacity earlier, supported by realistic funding and workforce lead times; define when resources should be redirected; minimise disruption to consultant job plans; and expand front-door therapy and JET capacity where funded.
Bed capacity and patient flow	Elective pathways were maintained with fewer cancellations than in previous years.	Bed occupancy remained above the 92% target. Medical outliers occupied surgical beds, and a high proportion of community hospital beds were occupied by patients who were medically fit for discharge.	Reduce avoidable inpatient demand, introduce criteria-led discharge, improve visibility of cardiology outliers in Epic, strengthen admission-avoidance pathways and agree the organisation's risk appetite in light of estate-related reductions in bed capacity.
Discharge and community pathways	Closer joint working across acute and community services supported flow, with established discharge-to-assess pathways providing a basis for improvement.	Complex discharges were delayed by social care placement constraints, particularly at weekends and bank holidays. Around 20% of	Bring referrals forward earlier in the week; improve acute-to-community pathways; provide prompt and complete discharge information, including night diaries, nutritional needs, mental capacity

		onward referrals were made on Fridays, when providers were less able to assess. Information required by complex discharge teams was not always complete or timely.	assessments, safeguarding referrals, medicines and transport arrangements; and reinforce discharge-to-assess responsibilities.
Seven-day services	Weekend cover on Dunlop Ward delivered operational benefits.	Weekend and bank-holiday shifts were not consistently funded, and planning focused too narrowly on medical cover rather than the wider multidisciplinary service.	Agree in advance which services and activities will operate across seven days, including diagnostics, therapy, discharge, community services and ward support; align job plans; and secure funding before implementation.
Respiratory and cardiology capacity	Additional respiratory consultants supported rapid assessment, treatment and earlier discharge. Respiratory virtual ward capacity increased from 25 to 30 beds, and a cardiology virtual ward was introduced.	Benefits depended on additional staffing and reliable supporting services, with financial and workforce constraints limiting sustainability. The Respiratory Support Unit that was planned to open– did not go ahead due to estates works.	Embed successful respiratory and cardiology models into the winter baseline, confirm funding and staffing early, and monitor utilisation, admission avoidance and discharge impact.
Community urgent care	The Harbour at Newton Abbot Hospital provided an additional community-based response.	UTCs and MIUs were often overwhelmed and sometimes closed early because of demand and workforce constraints.	Pool resources at Newton Abbot UTC, review opening hours and medical support, and strengthen care coordination and call-before-convey approaches so patients are directed to the most appropriate service.

Workforce resilience and wellbeing	Teams maintained services through Epic implementation and industrial action despite significant operational pressure.	Average sickness was 5.3%, clinical supervision was constrained and business continuity plans did not always account adequately for routine staffing shortages. Recruitment lead times of at least three months limited late deployment.	Begin recruitment and rota planning earlier; ensure business continuity plans reflect realistic absence levels; protect clinical supervision; and pre-agree when non-essential training and meetings will be stood down during peak pressure.
Finance and winter investment	Services were able to mobilise escalation measures when required.	The previous winter plan had no dedicated finance, leading to reactive spending on escalation, workforce, weekends and bank holidays.	Develop costed proposals with clear benefits, dependencies and sign-off; establish dedicated winter funding before mobilisation; and track expenditure and delivery through defined governance.
Diagnostics, Epic and point-of-care testing	Epic implementation was managed positively, with continuity of care maintained through a major system change.	Epic configuration and ordering processes created avoidable work, while unnecessary testing could delay pathways. Previous visibility of cardiology outliers was lost.	Establish a pathology and microbiology group to develop a point-of-care testing strategy; streamline Epic ordering and routine OT/PT care-planning configuration; and restore clear visibility of cardiology outliers.
Estates, facilities and mortuary resilience	Core support services continued to respond during periods of pressure.	Deep-cleaning capacity was constrained, and Medical Examiner referrals continued to affect mortuary flow.	Model winter deep-clean and mortuary demand, agree escalation capacity and triggers, and ensure Medical Examiner and facilities dependencies are included in operational readiness plans.

Expected Demand for Winter 2026/27

Historic demand data indicates that Type 1 ED attendances are expected to remain consistently high throughout winter 2026/27, rather than demonstrating a single sustained winter surge. Historical performance suggests daily attendances are likely to remain at a high baseline level, placing continued pressure on assessment, treatment and flow across urgent and emergency care services. Without further transformation of inpatient pathways and a continued shift towards Same Day Emergency Care (SDEC), admission avoidance services and HOT Clinics, emergency admissions would be expected to remain within the historic range of approximately 65–75 admissions per day, maintaining significant demand on acute bed capacity.

Seasonal pressures remain a key risk. Winter increases in influenza, RSV, COVID-19 and norovirus have the potential to increase patient acuity, extend lengths of stay, reduce available inpatient capacity through infection prevention and control requirements, and contribute to workforce pressures through staff sickness. These factors can rapidly impact patient flow, increase bed occupancy and place additional pressure on discharge pathways and community services.

The Trust's Winter Plan is therefore focused on managing high but variable front-door demand, responding effectively to intermittent respiratory and flu-related surges, and mitigating risks associated with increased acuity and constrained flow. A key part of this approach will be the continued expansion and optimisation of SDEC, admission avoidance pathways and HOT Clinics, alongside strengthened discharge processes and community capacity, to reduce emergency and unplanned admissions and ensure patients receive the right care in the right place at the right time.

Demand modelling

The medium-term demand model for winter 2026/27 is based on recent historical patterns of seasonal pressures, adjusted to take account of any warning signs emerging from supplementary information.

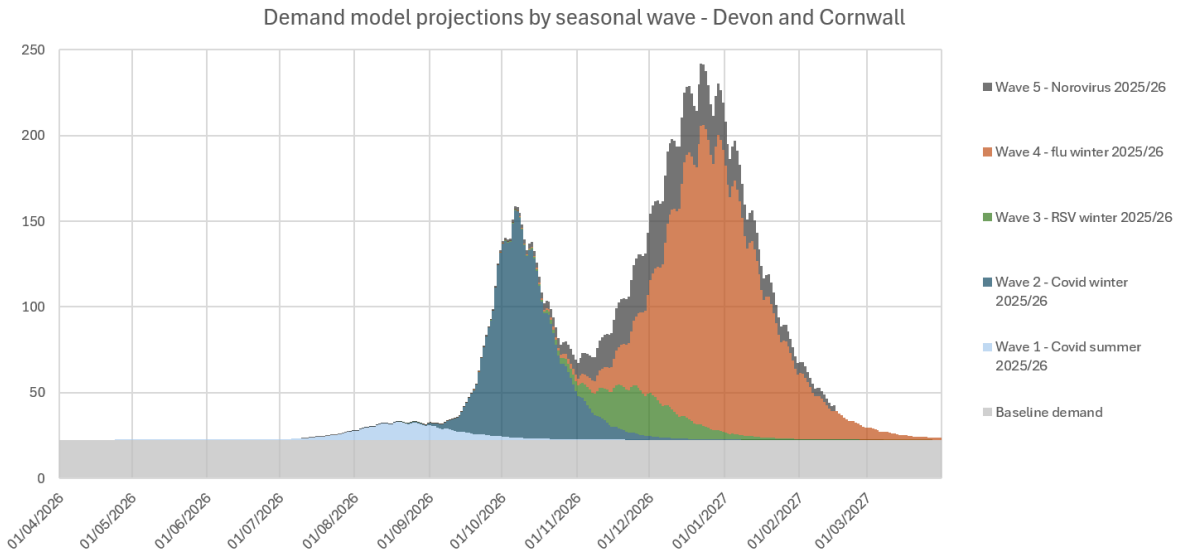
Analysis of previous years’ data demonstrates that an increase in ED demand in the winter months is primarily driven by both older people and very young children. This increased demand is strongly linked to respiratory infections but the size, shape and timing of the seasonal waves can vary each year.

The increased ED demand in winter for older people has a significant impact on acute hospital beds as older people are more likely to be admitted and once admitted, they tend to have a longer length of stay. This increase in demand will also place an additional pressure on complex discharge capacity.

We have produced daily predictive modelling that is aligned to the base case scenario. This will also be compared with actual demand throughout the winter to help the system to refine its response if thresholds are breached. We are able to adjust the parameters of the model on a regular basis so that the model can support

more real-time planning. The model predicts the 'bed' impact of the main infectious disease waves on the main acute trusts. This bed impact can include beds occupied by patients with these conditions or beds closed due to them (i.e. for norovirus etc). The base model demonstrated in chart 8 estimates that the peak in winter pressures will be surge of around 7.4% of the total system bed capacity. Understanding the timing and size of these waves is important when it comes to planning alignment and being a few weeks out can be critical. Thus it is important to have a base case to work from but also that this can be adjusted to reality.

Chart 8 – Demand model projections by seasonal wave – Devon and Cornwall. (1st April 2026 – 31st March 2027)



The winter surge can be split into a number of distinct phases characterised by the main infectious condition that is present: -

Initially there is a covid wave that in recent years has peaked in October. This usually starts to build quite rapidly after the schools return after the summer break. Whilst the prevalence of covid in the wider population is high at this time the likelihood of a patient being admitted for covid is relatively low. However, covid will often spread rapidly through the people in the hospital infecting both staff and patients. Thus, the covid wave can slow the pace of discharges and restrict capacity within the system

RSV wave normally peaks in November. This wave is mainly linked to an increase in demand for very young children. The recent rollout of vaccinations of pregnant mothers appears to have had a positive impact on the level bronchiolitis admissions for young children. We are expecting to see a similar positive impact again this year.

The flu wave is usually the largest of the infectious disease waves and normally peaks between December/ January. The level of intergenerational mixing over the Christmas period can often create a further surge in demand creating high pressure in the first weeks of January.

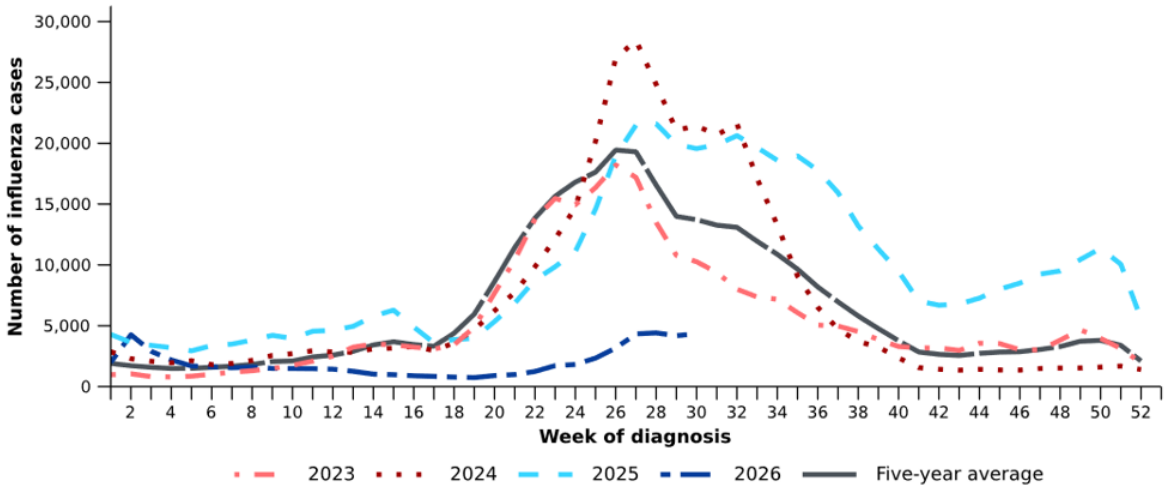
There are several other potential areas of demand including norovirus. Whilst outbreaks are more common in the winter they tend to be more localised and can occur at any given point over the winter. They often manifest themselves as bed closures but from a modelling perspective we assume a baseline level of capacity loss due to them over the period.

The weather is also known to be a variable. Whilst the general colder weather triggers the surge in infectious diseases any period of more extreme weather can also have a significant impact. Temperatures below freezing can increase the risk of slips, trips and falls. Cold weather can also impact on circulatory conditions which will also increase demand.

Winter flu forecasting – early view

To get an initial view of the potential seasonal demand for flu we often turn to what has happened in the recent winter in the Southern Hemisphere. Chart 9 shows the latest flu surveillance chart for Australia. The current year has seen a relatively low level of demand compared to recent years. Whilst we can't assume that the same pattern will play out in the UK the initial signs are positive.

Chart 9 - Notified influenza cases and five-year average by year and week of diagnosis, Australia, 2023 to 26 July 2026*



Historic trends in ED

Chart 10 demonstrates the trend in ED attendances for respiratory conditions by the chief complaint. Currently we are expecting to see a similar pattern in ED attendances in the coming winter. The most common chief complaints were dyspnoea (shortness of breath) or fever and these account for around 84.2% of total respiratory attendances.

Chart 10 – Average daily ED attendances (type 1) for Respiratory conditions by chief complaint (April 2023 – April 2026)

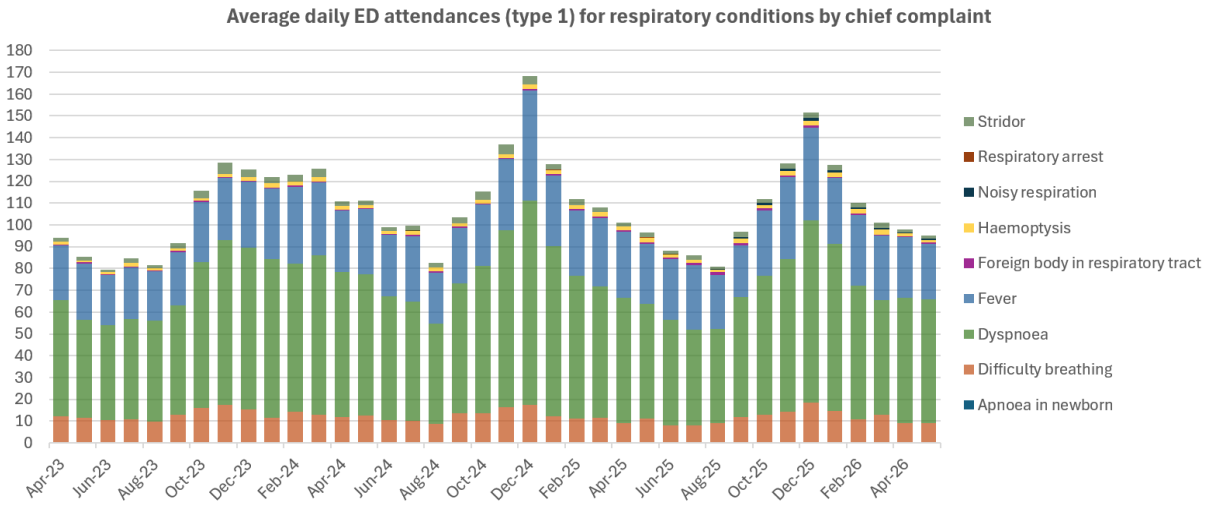
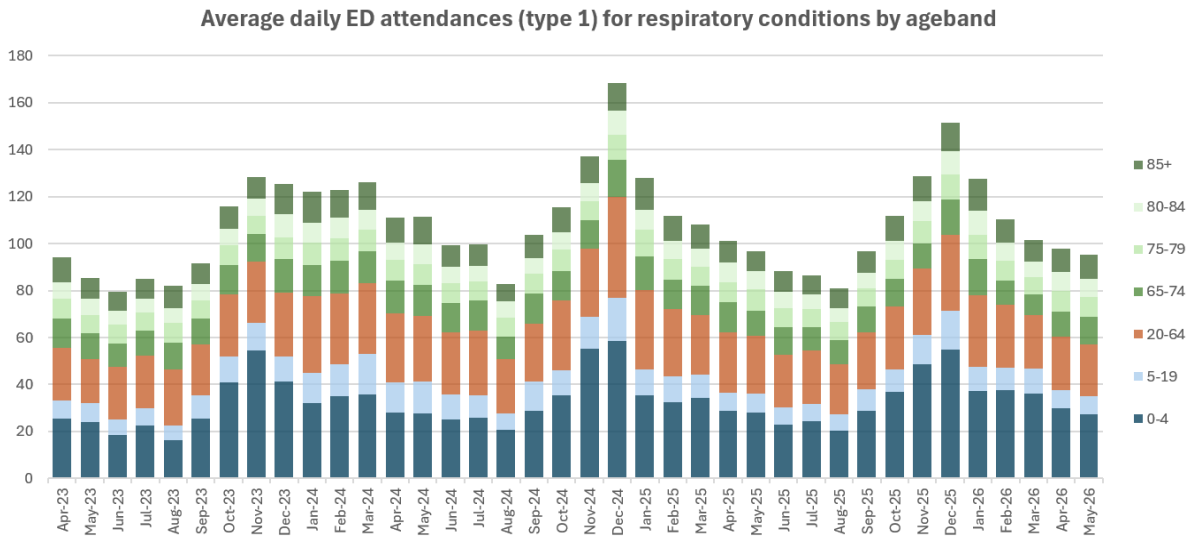


Chart 11 below shows the age distribution of ED attendances for respiratory conditions. A little over a third (36.8%) of all attendances are for children under 10 and a similar proportion (40.2%) are for people aged 60+. Young children often see an increase in ED attendances in November/ December linked to a surge in RSV with older people seeing a surge slightly later in December/ January.

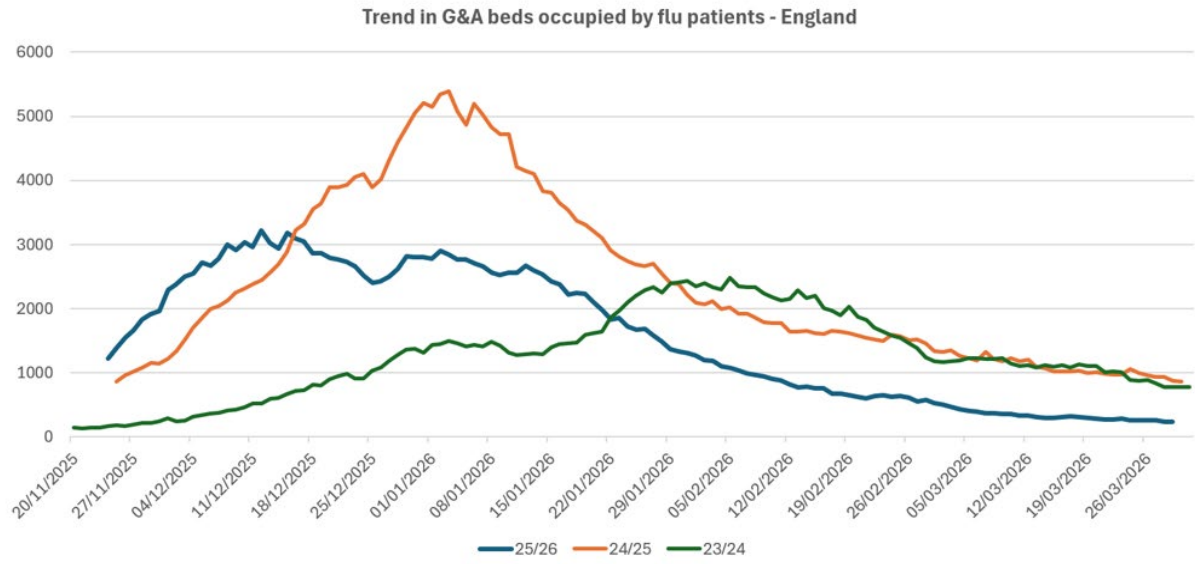
Chart 11 – Average daily ED attendances (type 1) for Respiratory conditions by ageband (April 2023 – April 2026)



Trend in beds occupied for flu

We are currently expecting a similar pattern in 2026/27 as was seen in previous years. However, as can be seen in Chart 12 there is a significant level of variation in the flu wave each year so it is important to have an approach that remains adaptable to the latest evidence. The peak beds occupied by flu often represent between 2-5% of the total bed capacity.

Chart 12 – Trend is G&A beds occupied by flu patients -England (20/11/2025-26-03/2026)

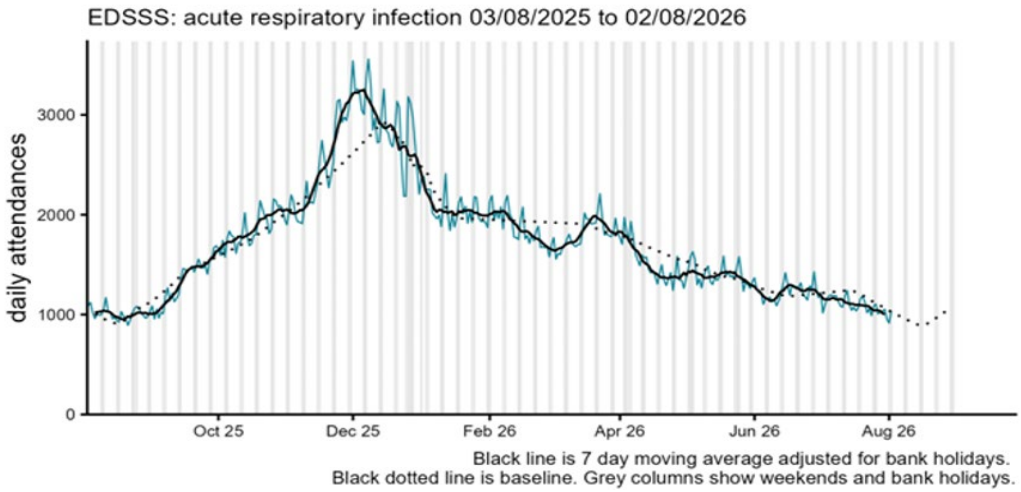


Whilst we often frame the winter surge in terms of hospital metrics of ED and emergency beds occupied it should also be recognised that the same surges in demand also impact on other areas including primary / community services etc.

Surveillance reports

Chart 13 provides an extract from the national surveillance report that are published each week. As they are aggregated to a national level they can be used to get a general idea of the spread of different conditions. More localised versions are also available.

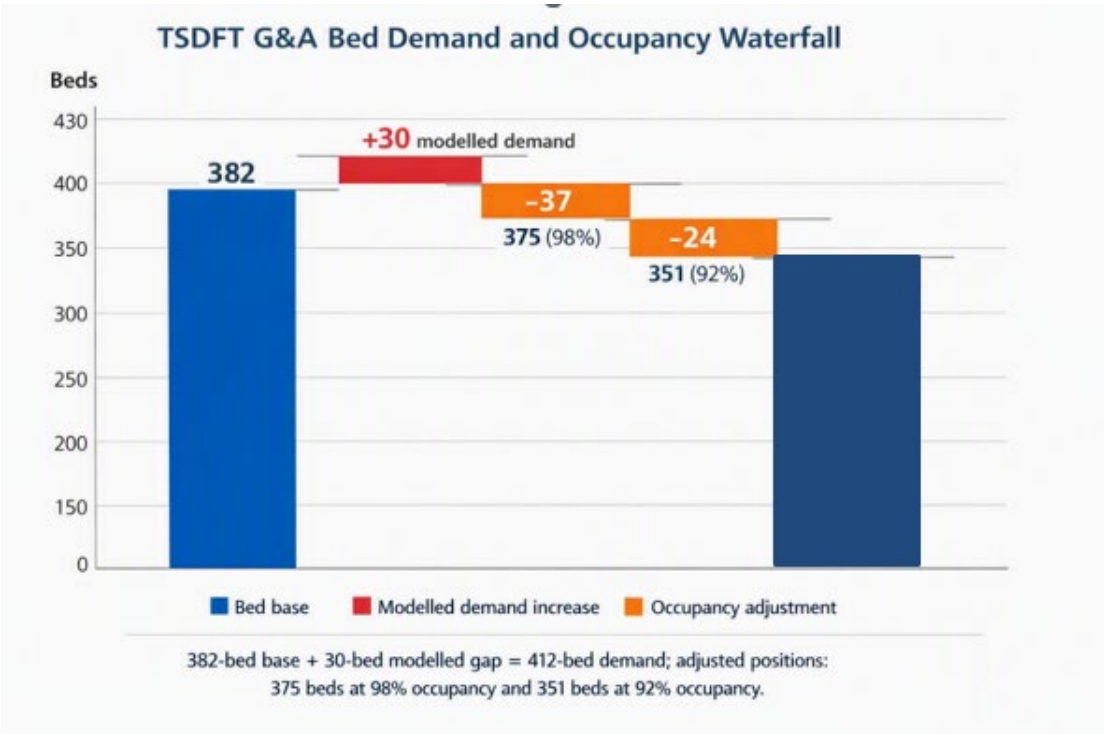
Chart 13 – Emergency Department Syndromic Surveillance System (EDSSS) acute respiratory infection (03/08/2025 – 02/08/2026)



We have also reviewed the UK Health Security Agency - UKHSA Winter Scenarios and Impacts documents as part of our winter planning. This draws on scenario generation workshops, subject matter expert review and available evidence and intelligence to provide likelihood judgements and illustrative impact metrics across key winter health threats. These scenarios, together with local demand data, infection surveillance and bed modelling, have informed planning assumptions for respiratory illness, influenza, RSV, COVID-19, norovirus, adverse weather and concurrent winter pressures.

BED GAP

Modelling indicates a 7.8% system bed gap. Applied to TSDFT's base of 382 general and acute (G&A) beds, this equates to an additional requirement of approximately 30 beds, taking modelled demand to 412 beds. To operate at the Trust's target occupancy of 92%, a further 31 beds would need to be available, resulting in an average capacity shortfall of 61 beds.



The modelling therefore indicates that the Trust is likely to operate above 100% of its core capacity throughout much of the winter, with demand exceeding available escalation capacity for sustained periods.

Trust Response to Closing the Internal Bed Gap

Eliminating Corridor Care Programme

The Eliminating Corridor Care Programme was established following the Trust's Corridor Care Summit and is organised around four strategic programmes:

- Right Care – making the right decision first time.
- Right Pathway – maximising alternatives to admission.
- Right Flow – improving movement through hospital and discharge pathways.
- Right Coordination – creating the optimum conditions for flow.

The operating model for eliminating corridor care is demonstrated in figure 1.

Together these programmes span the patient journey from first contact through to discharge and provide the framework for delivery of the Trust's winter priorities

The aim of the programme is to eliminate the routine use of corridors and other non-designated clinical areas for patient care by improving flow, our patient pathways, strengthening escalation responses and ensuring that patients are transferred to the most appropriate care environment as early as possible.

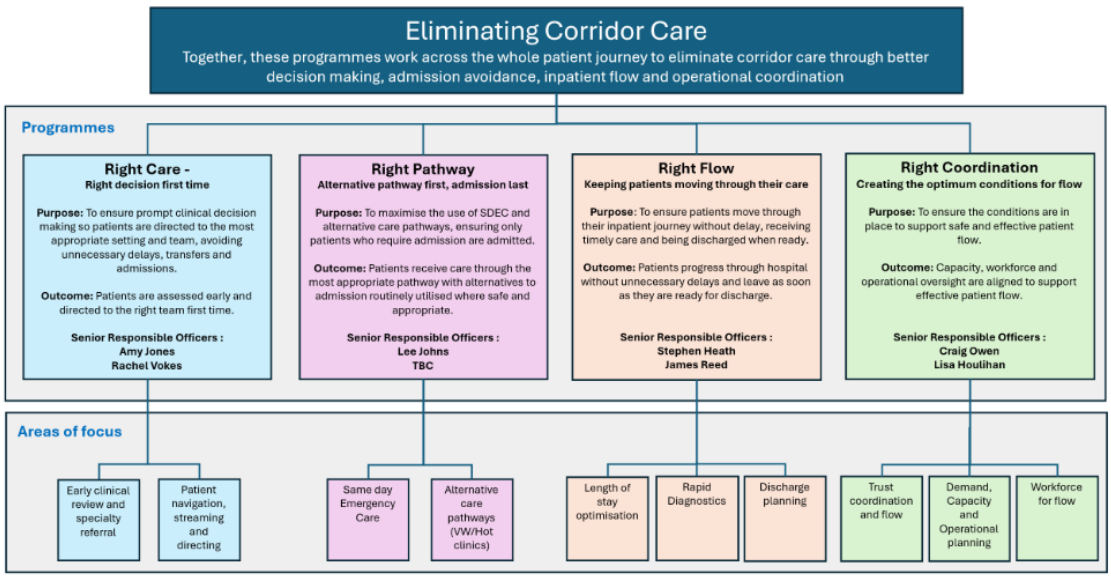
The Eliminating Corridor Care programme is a core component of the Trust's winter approach and is aligned to the national expectation that corridor care is treated as a

patient safety priority. The programme brings together urgent and emergency care, site operations, inpatient wards, discharge teams, community services and system partners. It focuses on improving flow from the Emergency Department, earlier senior decision-making, timely movement to assessment and inpatient areas, reducing avoidable admissions through SDEC and admission avoidance pathways, and strengthening discharge processes so that patients are cared for in the right place at the right time.

The programme will aim to be delivered through a focused set of workstreams rather than a broad list of improvement ideas, ensuring that effort is directed towards the changes most likely to improve patient safety, experience and operational flow. Delivery will be supported with named operational and clinical leads, supported by the improvement team, with agreed milestones and measurable outcomes. These will include front-door flow, ambulance handover, assessment unit capacity, ward processes, discharge acceleration, escalation standards and the consistent use of alternatives to admission. Particular focus will be placed on reducing delays at key handover points in the pathway, improving the reliability of early senior review, maximising SDEC and virtual ward utilisation, and ensuring that agreed escalation actions are enacted consistently when demand exceeds capacity.

Progress will be monitored through established governance arrangements, with regular reporting against agreed safety, quality and flow metrics. This will include oversight of corridor care episodes, 12-hour waits, ambulance handover delays, Emergency Department crowding, assessment area occupancy, discharge performance and bed occupancy. The workstreams have been aligned to the Model Emergency Department, Model Acute Pathway and Model Discharge Pathways, in line with national priorities and expectations for winter, ensuring that the programme forms part of a coherent Trust-wide approach to improving urgent and emergency care flow.

Figure 1 : operating model for eliminating corridor care



Medicine and Urgent and Emergency Care Group Priorities

The Medicine and Urgent and Emergency Care Group's winter priorities are to improve front-door flow, reduce avoidable admissions, enable earlier senior decision-making and direct patients to the right clinician, service or pathway at the earliest opportunity. Delivery is aligned with the national Model Emergency Department and Model Acute Pathway, including timely clinical streaming, senior assessment, effective use of urgent treatment and ambulatory pathways, and avoiding use of the Emergency Department as a default holding area. It also responds to GIRFT urgent and emergency care recommendations by reducing unwarranted variation, improving acute medical flow, strengthening frailty and specialty interfaces, reducing ambulance handover delays and improving patient and staff experience.

Newton Abbot Urgent Treatment Centre optimisation. The model will increase GP input, develop practitioner skills and reinforce Newton Abbot UTC as the appropriate centre for minor illness, reducing avoidable attendance at the Torbay site. Booked appointments remain on track to go live by the end of September 2026.

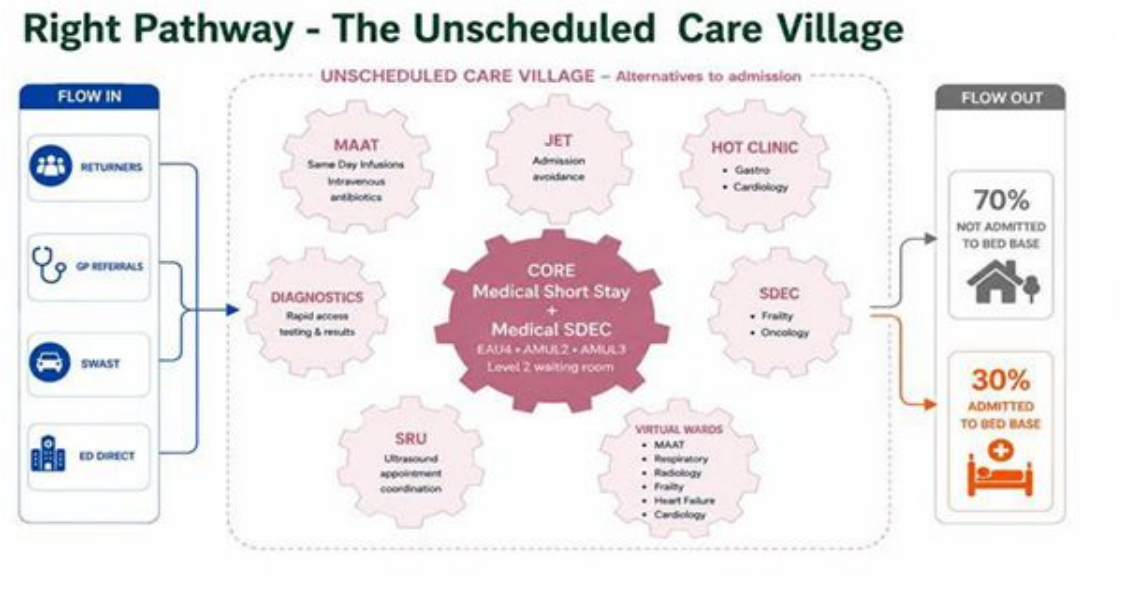
Non-admitted front-door pathways. Findings from the GIRFT Missed Opportunities Audits are being translated into executive SRO-supported programmes covering non-admitted pathways within the ED footprint, workforce skill development and earlier streaming to the right clinician, workstream or pathway. The model will introduce earlier specialty streaming; clinically appropriate redirection to NHS 111, Pharmacy First and general practice; and practitioner-led preparation for ambulatory pathways. Nurses and practitioners will use approved SOPs and PGDs to request relevant imaging and diagnostics and standardise early referrals, so patients are ready for timely medical or practitioner review.

This workstream will launch on 15 October 2026 and aims to improve four-hour performance for non-admitted patients by 10 percentage points by 31 October 2026.

Specialty queue management. Each specialty will complete a queue-management plan by 15 September 2026 for implementation in mid-October. Plans will define how activity will be managed differently, the conditions and operational support required, and whether HOT clinics or alternative clinical spaces are appropriate.

Unscheduled Care Village and standalone SDEC. The wider Unscheduled Care Village will bring together Medical SDEC, specialty SDEC, diagnostics, admission-avoidance services, HOT clinics and virtual pathways. Its SDEC-first operating model will provide suitable patients with rapid assessment, treatment and discharge without defaulting to inpatient admission. The standalone service will launch on 15 October 2026 and operate Monday to Friday, 08:00–20:00.

Figure 2 : Right Pathway – The Unscheduled Care Village



Specialty Take. From 9 September 2026, a one-month pilot weekday cardiology MDT at 13:00 will review patients identified in ED and AMU by specialist nurses. The Cardiologist of the Week will prioritise complex cases and patients suitable for discharge, supporting earlier decisions and improved flow to cardiology wards. The pilot will use existing resources, with no anticipated impact on elective activity, and will be reviewed by the team.

Respiratory Specialty Take. A dedicated respiratory assessment will operate each Monday across ED, AMU and relevant assessment areas, providing early specialist input to support prompt clinical decisions, timely management plans and improved patient flow.

Respiratory and Cromie Medical Outliers. From 21 December 2026 to 8 January 2027, an additional respiratory consultant will work across Midgley and Cromie wards to support earlier clinical decisions, timely discharge and improved flow for respiratory patients and medical outliers.

HOT clinics. The Care Group will expand rapid specialist review for selected patients who do not require immediate admission but need timely consultant-led follow-up, diagnostics or treatment planning. Cardiology HOT clinics will be prioritised to support earlier discharge from assessment areas, reduce short-stay admissions and provide a safe alternative to inpatient care. Delivery will be governed by clear referral criteria, agreed response times and senior clinical oversight, with routine monitoring of admission avoidance, length of stay and patient experience.

Heart Failure Virtual Ward. Reintroduction of the service is subject to securing the required funding and recruiting the necessary workforce. Once mobilised, it will provide an additional admission-avoidance and early supported-discharge route for suitable patients who can be safely managed through remote monitoring, specialist

review and community-based support. The pathway will strengthen coordination between cardiology, acute medicine, community services and virtual ward teams, reduce inpatient bed demand, and maintain clear clinical oversight and timely escalation if a patient deteriorates.

Frailty Transformation – Growth of Current Frailty Services

The Trust's winter frailty response builds on the existing Harbour Frailty Service. By 21 August 2026, 1,423 referrals had been received through the GP triage line, with referrals increasing by 32% between June and August compared with the previous three months. Admission was avoided for 58% of referrals: 41.4% were managed through a Harbour pathway and 16.6% through advice alone. This demonstrates the impact of senior clinical triage and integrated frailty care closer to home.

Current gaps are lower referral rates from Torbay UEC pathways and reduced ability to offer alternatives to conveyance or admission later in the day and towards the end of the week. The winter offer will therefore strengthen pathways from SWASFT, Torbay ED and AMU, aligned with planned Coral SDEC and ED pathways. This requires no additional resource but is dependent on PTS and SWASFT capacity.

Harbour SDEC and Harbour@Home will extend to 20:00 Monday–Friday, enabling later referrals, while senior clinical telephone triage and Harbour@Home will expand to weekends. This will strengthen links with UCR and Intermediate Care Teams and support management of greater acuity in the community. The expanded Harbour model is expected to be operational by the end of January 2027.

The quantified winter opportunity from the current growth plan is estimated at approximately 5–7 patient episodes per day, primarily through the Harbour Frailty Service, Harbour@Home and the Community X-ray Service. This should be treated as an operational planning assumption rather than a cash-releasing benefit and will require validation.

Table 1 - Growth of Current Frailty Services

Service Pathway	***Winter activity***	***Estimated increase in patient episodes impacted***
Harbour Frailty Service: Harbour@Home and Harbour SDEC	*58% of patients avoid an attendance or admission currently.* *c. 4.4 patients/day avoid admission via Harbour pathway or advice only*	*c. 1-2 attendances avoided (+/- admission) via step-up pathway* *c. 2 admissions per day (Mon-Fri) avoided via step-down pathways from UEC.* *Impact of weekends as yet unquantified*

Community x-ray	*Forecast winter ramp-up: 30 scans in November, 45 in December and January and 60 from February onwards*	*c. 1 patient per a day in November, c.1.5 per day in December/January rising to c.2 per day from February onwards*
Ambulatory HI Pathway	*No baseline available*	*Unquantified currently.*
	Combined	***c. 5 -7 patients***

Growth of the frailty model will also be supported by the Community X-ray Service, which provides mobile diagnostics for suitable falls, suspected fracture and respiratory patients in community settings. This enables clinically appropriate patients to receive imaging without default conveyance to the Emergency Department. The planned winter ramp-up is forecast at 30 scans in November, 45 scans per month in December and January, and 60 scans per month in February and March. This equates to approximately one patient episode per day in November, rising to around two patient episodes per day by February and March.

The Ambulatory Head Injury Pathway will provide a further extension of the frailty offer by creating a non-ED CT route for clinically suitable older people living with severe frailty in care homes or community hospitals following suspected fall-related head injury. The pathway is designed to avoid default ED conveyance and precautionary admission where patients can safely remain in their current place of care while senior triage, CT scheduling and clinical decision-making take place. Activity is not yet baselined and will therefore be tracked prospectively throughout winter, including referral volumes, acceptance rates, CT and reporting times, ED conveyance avoided, unplanned ED attendance or admission within 72 hours, incidents and patient or carer feedback.

Successful delivery will depend on maintaining resilience across Harbour, Urgent Community Response, SDEC, radiology, transport, community nursing, therapy, care home support and social care. By strengthening Harbour, expanding access to community diagnostics and developing ambulatory alternatives for selected head injury patients, the Trust will increase the number of frail older people managed closer to home, reduce avoidable acute demand and support improved flow across urgent, acute and community pathways throughout winter.

The GIRFT audit reinforced the importance of frailty pathways, identifying missed opportunities to utilise frailty services earlier and highlighting that some of the longest waits were experienced by patients living with frailty.

Planned Care Group Priorities

The overarching aim for planned care is to maintain elective activity throughout the winter period. Protecting planned care capacity will be critical to minimising elective cancellations, maintaining recovery against RTT standards, and ensuring patients continue to receive timely treatment. A key principle of the plan is that day-case capacity should remain to be protected and not utilised for escalation.

Alongside protecting elective services, the plan seeks to support operational flow and admission avoidance across the care group. This will be achieved through a combination of enhanced same-day emergency care and improvements to seven-day service provision. Collectively, these measures are designed to maintain patient flow, reduce unnecessary admissions and ensure organisational resilience throughout periods of increased demand.

Trauma and Orthopaedic Capacity

Trauma and Orthopaedic services will review winter rotas to ensure sufficient capacity is available for hip fracture and knee trauma activity throughout the peak winter period. Consultant annual leave and wider staffing arrangements will be reviewed in advance to optimise workforce availability, support timely decision-making and maintain effective trauma flow. Ella Rowcroft Ward will continue to flex its inpatient capacity from 14 core beds plus 2 high-care beds, increasing up to 21 beds in total as required to respond to winter demand. Additional nursing staff is required when increasing bed capacity on Ella Rowcroft and is a cost pressure.

A test of change will commence on Ainslie ward from 29 September 2026 to improve time to ward for patients with a confirmed fractured Neck of Femur (NOF). As part of the test, we will establish a dedicated four-bed NOF assessment unit within D Bay. Anticipated benefits include faster transfer from the Emergency Department to the appropriate ward environment; earlier, coordinated multidisciplinary assessment, treatment and optimisation for surgery; an improved patient experience through a clearer and more consistent pathway; reduced delays and variation in care, supporting timely surgery and earlier recovery; and better use of dedicated capacity to improve patient flow across the hospital.

Elective Protection and Escalation Triggers

Current elective stand-down arrangements will be reviewed to ensure a consistent and proportionate response to periods of operational pressure. Consideration will be given to establishing formal trauma escalation triggers that support objective decision-making and provide clarity regarding when elective activity should be impacted. The existing principle of capping inpatient elective activity during significant escalation periods will be retained unless specific authorisation is provided to proceed.

Surgical Receiving Unit Expansion

Planned capital developments associated with the relocation of the Surgical Admissions Unit will provide additional capacity within the Surgical Receiving Unit for planned theatre admissions, creating capacity for 3-4 additional patients within SRU daily, reducing the number of patients held in ED while capacity is created to support admission. These developments are expected to improve patient flow, reduce pressure on existing clinical areas and provide greater flexibility for managing

elective admissions during the winter period, supporting both planned and urgent care pathways.

Oncology SDEC and Assessment Model

Opportunities will be explored to establish an Oncology Same Day Emergency Care (SDEC) model linked into the unscheduled care village. The objective is to provide rapid assessment and treatment for oncology patients, reducing avoidable admissions while improving patient experience and access to specialist care. Subject to operational feasibility, a pilot implementation will be considered to evaluate impact and inform future service development.

Seven-Day Alcohol Care Team

Extending the Alcohol Care Team service to provide seven-day coverage. Evidence from the current service demonstrates a significant impact on patient flow, outcomes and quality of care, with the potential to reduce winter pressures across the acute system.

The Alcohol Care Team has already achieved a reduction in average length of stay from 6.4 days to 4.4 days for patients admitted during the week. Extending specialist provision to weekends is expected to ensure equitable access to assessment and treatment throughout the week and further reduce average length of stay to approximately 3.5 days per patient. This reduction in hospital stay, combined with improved management of alcohol-related admissions and more effective discharge planning, is expected to release a substantial number of bed days during the winter period.

The service has also demonstrated a reduction in alcohol-related re-admissions. Monitoring data indicates that 65 admissions were avoided over a three-month period due to interventions provided by the Alcohol Care Team. Based on current activity levels, this equates to approximately 364 avoided admissions per year, generating an estimated 1,600 bed days saved annually.

Additional benefits include improved management of alcohol withdrawal through specialist seven-day support, reduced risk of serious incidents and case reviews highlighted in the CQC report, compliance with NICE guidance and NHS Long Term Plan expectations, and the removal of inequity for patients admitted at weekends.

Expected Benefits

- Reduction in average length of stay from 4.4 days to approximately 3.5 days per patient through seven-day specialist coverage.
- Estimated 1,600 bed days saved annually through avoided admissions and improved patient management.

- Approximately 364 admissions avoided per year through specialist intervention.
- Improved patient outcomes and safer alcohol withdrawal management.
- Reduced risk of serious incidents and associated case reviews.
- Compliance with NICE guidance (CG100, CG115, NG50) and NHS Long Term Plan ambitions.
- Equitable access to specialist alcohol care seven days per week.

Gastroenterology Front Door Ward Round

Gastroenterology will provide a two-hour specialty ward round in the Emergency Department each morning, enabling early senior review of patients with suspected or confirmed gastroenterology conditions. Bringing specialist assessment to the front door will support faster diagnosis and treatment planning, timely access to appropriate investigations and pathways, and earlier decisions to discharge, refer to ambulatory or outpatient follow-up, or admit directly to the most appropriate specialty bed.

The anticipated benefits are fewer avoidable admissions, reduced duplication and delays in specialty advice, shorter Emergency Department waits and length of stay, improved use of ambulatory and same-day pathways. Earlier specialty ownership should also improve patient experience, reduce outlying and unnecessary bed use, and strengthen coordination between Emergency Medicine, Gastroenterology, diagnostics and outpatient services.

The pilot will assess patient volumes, time to specialty review and decision, admission and discharge outcomes and the workforce and operational requirements needed for sustainable delivery. Findings will inform refinement of the model and whether similar front-door specialty ward rounds should be introduced more widely.

Day-Case Productivity

Maintaining and improving day-case productivity will remain a key focus throughout winter. Services will continue to maximise day-case utilisation, reduce unnecessary overnight stays and reinforce existing good practice. Additional opportunities to increase throughput and preserve capacity will be identified to support elective recovery and minimise the impact of winter pressures on planned care services.

Clinical Support Services

Medical Imaging continues to play a pivotal role in supporting patient flow and timely discharge across the Trust. A virtual ward pathway incorporating imaging follow-up is currently in development to facilitate safe discharge and reduce unnecessary hospital stays. In addition, the X-ray Car service, delivered in partnership with Mobile Medical Diagnostics, is due to go live in October 2026 and is expected to support up

to nine patients per day, helping to avoid hospital conveyances, reduce emergency department attendances, and minimise bed occupancy during periods of peak demand.

Ongoing monitoring of equipment resilience and workforce capacity remains a priority, particularly within Ultrasound, MRI and Interventional Radiology services, where operational pressures persist. The Community Diagnostic Centre (CDC) continues to be utilised to its full potential, maximising diagnostic capacity and enabling patients, including those on urgent and suspected cancer pathways, to be seen as quickly as possible.

Point-of-Care Testing (POCT) in Microbiology is under financial review, with a forecast requirement of 650 boxes of Quad Kits. Last winter, POCT spending exceeded the budget by £97,318, and at present, there is no dedicated funding to cover a repeat overspend this year. The department is looking to bulk buy at a lower cost which may reduce any overspend by up to £35k. Confirmation from Finance is awaited regarding other funding sources utilised previously and potential solutions for covering anticipated costs; if unresolved, this represents a significant cost pressure moving into the winter period. A small project in Paediatrics ED is planned to assess POC Lateral Flow tests this year, which may alleviate costs if successful.

Norovirus near patient testing was £3.5k overspend last year and is already on track to be overspent with no funding sources identified; Another winter of outbreaks will compound this.

Mortuary has established arrangements in place to ensure appropriate Medical Examiner Office cover over Christmas and bank holiday periods. These arrangements will continue to support timely transfer and flow during periods of peak demand and will continue to be monitored throughout winter.

Families and Community Services

Paediatrics

The paediatric winter plan is designed to ensure children and young people continue to receive safe, timely and effective care throughout periods of increased seasonal demand. Although paediatric activity does not materially contribute to the Trust's adult bed mitigation requirements, effective paediatric urgent care pathways remain important for patient experience, clinical safety, ED flow and the wider urgent and emergency care system.

The objectives of the paediatric winter plan are to:

- Anticipate and manage seasonal increases in paediatric demand.
- Maintain safe, timely and high-quality care for children and families.
- Improve flow across the whole paediatric urgent care pathway, including the Emergency Department, SSPAU and Louisa Cary Ward.

- Ensure children and young people are seen in the right place, by the right team, at the right time.
- Strengthen operational resilience during periods of peak demand.
- Support delivery of the national ambition to improve the proportion of children seen within four hours.

Developing the Paediatric Urgent Care Model

SSPAU is a central component of the Trust's paediatric urgent care pathway, providing rapid assessment, observation and treatment for children and young people who require specialist paediatric input. Its role is to support timely decision-making, avoid unnecessary admission where appropriate and ensure children are managed in the most appropriate clinical setting.

The paediatric team will continue to explore how SSPAU, ED and inpatient paediatric services can work together most effectively during periods of increased demand. This will build on learning from previous winters, current performance data, breach reviews and emerging best practice across paediatric urgent care services.

Internal Professional Standards will be developed jointly across paediatric and Emergency Department services to support timely referral, assessment, senior decision-making, transfer and escalation. The aim is to create shared expectations across the pathway, reduce variation and support a consistent response during periods of pressure.

Internal Professional Standards

A key priority for Winter 2026/27 will be the development and implementation of paediatric Internal Professional Standards across Emergency Department, SSPAU and inpatient paediatric services.

The standards will establish agreed expectations for:

- Referral processes between ED and paediatrics.
- Response times for paediatric assessment.
- Escalation arrangements when delays occur.
- Ownership and accountability throughout the patient journey.
- Senior clinical review requirements.
- Management of periods of significant operational pressure.

The aim is to reduce avoidable delay, improve consistency, support earlier senior decision-making and strengthen collaboration between teams during periods of peak demand.

Respiratory Preparedness

The expected winter surge in paediatric demand is closely linked to seasonal respiratory illness, including RSV, bronchiolitis, viral wheeze and asthma exacerbations.

To support operational readiness the service will:

- Maintain oversight of respiratory demand and capacity.
- Review escalation arrangements for children requiring respiratory support.
- Ensure equipment availability and readiness.
- Review staffing competencies and training requirements.
- Maintain close working relationships with ED and inpatient teams.
- Monitor emerging demand trends to support early escalation where required.

Workforce and Operational Resilience

The paediatric service will undertake proactive workforce planning ahead of the winter period to ensure resilience across SSPAU, Louisa Cary Ward and associated services.

This will include:

- Review of annual leave and rota gaps.
- Identification of vulnerable shifts and escalation arrangements.
- Monitoring of sickness levels.
- Review of workforce requirements linked to any SSPAU test of change.
- Clear escalation arrangements when staffing pressures arise.

Governance and Monitoring

Delivery of the paediatric winter plan will be overseen through established Care Group governance arrangements and linked to the wider Trust winter planning framework.

Performance will be monitored through:

- Paediatric four-hour performance.
- Number and causes of breaches.
- Referral and review times.
- Transfer delays.
- SSPAU utilisation.
- Ward occupancy and escalation activity.
- Workforce metrics.
- Patient safety incidents and feedback.

The focus throughout Winter will be on improving flow across the whole paediatric pathway and strengthening collaboration between services.

Womens Health Services

Maternity will manage winter pressures in accordance with the Regional Maternity Escalation Policy & Operational Pressures Escalation Levels (Maternity Framework) Version 4.3. Daily monitoring of capacity, acuity, workforce and demand will support the early identification and escalation of operational pressures, ensuring appropriate mitigating actions are implemented at the earliest opportunity. The service will prioritise safe maternity and neonatal care, maintain access to urgent and time-critical women's health pathways, support timely discharge and maintain effective infection prevention measures throughout the winter period. Established governance arrangements will provide oversight of safety, quality, workforce and operational performance to ensure the continued delivery of safe and effective care.

Gynaecology will maintain safe access to urgent, emergency and elective care throughout the winter period through proactive management of capacity, workforce and operational pressures. The service will prioritise cancer and clinically urgent pathways, protect elective activity wherever possible, and maximise the use of outpatient and day case to reduce unnecessary admissions and support patient flow. Regular review of performance, capacity and quality indicators will ensure risks are identified early and appropriate mitigations implemented, supporting the continued delivery of safe and effective care during periods of increased seasonal demand.

Community Plan

Community Services will deliver targeted changes to avoid unnecessary admissions, accelerate discharge and make more effective use of community capacity. Priorities for winter are to expand joint working between Urgent Community Response (UCR) and the Frailty Virtual Ward, strengthen daily management of Discharge to Assess (D2A) and intermediate care capacity, and intensify action to reduce No Criteria to Reside (NCTR) and length of stay.

Urgent Community Response will be expanded through daily reprioritisation of locality workloads, closer alignment of community nursing resource and protected capacity during periods of system pressure. Virtual Ward clinicians will have direct access to UCR teams to support admission avoidance for higher-acuity patients, with a risk-based model extended across the Trust footprint. Integration with Jack Sears will introduce a 72-hour short-stay option for suitable patients, supported by Virtual Ward medical oversight. The aim is to increase performance against the two-hour response standard to 94% and reduce avoidable conveyance and admission.

Locality pharmacists aligned to intermediate care and care homes will continue to focus on targeted medicines review for people at risk of admission or delayed discharge, earlier identification of medicines-related barriers, and support for safeguarding enquiries where medicines management is a contributing factor.

Community Nursing Teams will flex capacity towards UCR and admission-avoidance activity when pressure rises, supported by daily operational prioritisation.

Greater use of third-party delegation to carers and care homes will enable appropriate elements of care to be delivered safely without avoidable clinical visits, while specialist nursing input will be targeted to people at greatest risk of deterioration or hospital admission.

The Discharge Hub, complex discharge and NCTR improvement programme will be strengthened through daily validation of NCTR status in EPIC, daily review of medically optimised patients and active monitoring of Pathway 2 and Pathway 3 authorisations. Additional complex discharge meetings will be convened when system pressures require, supported by more accurate recording of delays, revised triage arrangements for Discharge Liaison Nurses and Trusted Placement Advisor input for care-home returns and new placements. Band 7 clinicians will triage all D2A referrals; Hub clinicians will undertake environmental visits where these can remove a discharge barrier; and additional night support will be used selectively to maintain Home First pathways. The programme aims to maintain NCTR at 8–12% and reduce average length of stay by 0.5 days across all discharge pathways.

Jack Sears, Mapleton and intermediate care will operate with active daily oversight of occupancy and length of stay. The new focus is to maximise step-up and step-down use, support same-day transfers wherever possible, utilise block-booked capacity and connect the facilities more directly with Frailty, Virtual Ward, community and inpatient teams. The target is to maintain occupancy above 80% while avoiding unnecessary long stays.

Adult Social Care integration will focus on faster joint resolution of complex cases through daily system oversight, shared escalation and earlier identification of placement or package-of-care barriers via our Length of Stay programme. Health and social care teams will use the Better Care Fund-supported intermediate care, UCR and discharge pathways. Workforce and budget transition arrangements will continue throughout the winter to support readiness for Adult Social Care duties to be managed by Torbay council from April 2026.

Length of Stay and community hospitals will be managed through an enhanced weekly programme linked to the Eliminating Corridor Care work. Community teams will contribute to acute and community hospital reviews to identify earlier discharge opportunities, strengthen expected-date-of-discharge discipline and increase step-up use from the community. Community multidisciplinary teams will review intermediate care length of stay and escalate delays that prevent timely movement home.

Delivery will be tracked through daily:

- Review of NCTR validation
- UCR two-hour response
- D2A availability
- Intermediate care occupancy
- Complex discharge caseload

Weekly review of:

- NCTR trajectory, length of stay
- Virtual Ward use
- step-up capacity
- care-home delays

Monthly assurance against:

- the 8–12% NCTR,
- 80% block-bed occupancy
- 94% UCR response targets.

Associate Directors of Operations and Community Service Managers will provide joint oversight and escalate variance through the Trust's winter governance arrangements.

Unfunded or funding-dependent elements to our plan

Element	Funding status	Evidence in the plan
Heart Failure Virtual Ward	**Unfunded / funding required**	Reintroduction is explicitly subject to securing the required funding and recruiting the necessary workforce.
JET expansion or extended hours	**Unfunded expansion**	Any extension or change requires additional investment because current resource is already stretched and cannot support an expanded model without affecting inpatient therapy capacity.
Microbiology point-of-care testing	**No dedicated funding**	Last winter's spend exceeded budget by £97,318. No dedicated funding is available for a repeat overspend. Bulk purchasing may reduce pressure by up to £35,000 but does not remove it.
Norovirus near-patient testing	**No funding source identified**	The service overspent by £3,500 last year and is already forecast to overspend, with no funding source identified.
Ella Rowcroft escalation beds	**Cost pressure**	Flexing from 14 core beds plus two high-care beds to 21 beds requires additional nursing staff and is explicitly described as a cost pressure.
Standalone SDEC / Unscheduled Care Village	**Funding not evidenced**	A launch date and weekday operating hours are planned, but as the model is established, additional workforce and funding maybe required.
HOT clinic expansion	**Funding not evidenced**	Expansion is intended and governance arrangements are described, but no confirmed workforce or funding source is identified.

Gastroenterology front-door ward round	**Pilot; sustainable funding unconfirmed**	The pilot will assess workforce and operational requirements needed for sustainable delivery, indicating that the recurrent model is not yet confirmed.
Enhanced seven-day Site Operations cover	**Funding to be released via restructure and change in on Call payments**	The enhanced 08:00–20:30 seven-day model from January 2027 is described, but no funding source or approved establishment is identified.

Pre-Christmas Occupancy Reduction Programme

The Trust will implement a targeted occupancy reduction down to 92% programme during December 2026 to improve resilience ahead of the Christmas and New Year period.

The focus will be on:

- Admission avoidance
- Accelerating discharge planning for patients approaching expected discharge dates.
- Reducing the number of patients with long lengths of stay.
- Maximising Pathway 0 discharges.
- Increasing utilisation of community capacity, virtual wards and intermediate care services.
- Earlier identification of patients requiring Pathway 1-3 arrangements.
- Increased executive oversight of occupancy and discharge performance.

Progress will be monitored through daily Safety and Flow meetings and weekly reviews via our Length of stay programme. The aim is to maximise available capacity entering the Christmas period whilst maintaining safe patient care and supporting elective activity.

Performance Trajectories and Delivery Assurance

Table 2 sets out the Trust Board-approved operational performance trajectories for 2026/27 across the following key areas:

- Emergency Department (Type 1) 4-hour performance
- 12-hour waits from decision to admit
- Referral to Treatment (RTT) pathways
- National cancer performance standards

The Winter Plan has been developed to support delivery of these trajectories and to mitigate the principal risks associated with increased seasonal demand. Planned interventions focus on improving patient flow across the system, optimising discharge processes, expanding Same Day Emergency Care (SDEC) and admission avoidance pathways, strengthening frailty services, maximising community capacity, and ensuring robust operational escalation arrangements are in place.

Delivery against the agreed performance trajectories will be monitored throughout the winter period through established governance and performance management arrangements. Where variance from plan or emerging risks are identified, timely corrective actions will be implemented to support recovery and maintain progress towards year-end objectives.

Table 2: Operational performance trajectories over a 12-month period (April 2026 to March 2027)

			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												
	RTT % within 18 weeks	Percenta	63.30%	60.80%	57.00%	59.00%	61.00%	62.00%	63.50%	65.50%	66.50%	69.00%	71.75%	73.80%
E.B.27	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	Percenta	47.98%	45.47%	57.45%	72.98%	76.99%	82.92%	81.02%	81.16%	81.69%	80.63%	81.02%	80.88%
E.B.35	Percentage of patients receiving a first definitive treatment for cancer within 62 days of receipt of an urgent GP (or other referrer) referral for urgent suspected cancer/breast symptomatic referral/an urgent screening referral/consultant upgrade	Percentag	78.11%	81.71%	78.77%	79.25%	79.89%	79.48%	82.66%	81.01%	81.82%	79.23%	79.14%	80.75%
E.B.38	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	Percentag	94.27%	94.12%	93.56%	94.01%	94.02%	94.10%	94.74%	94.71%	94.34%	94.57%	93.80%	94.42%
E.M.13	Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	Percentag	71.00%	72.00%	73.00%	75.00%	77.00%	76.00%	76.70%	77.50%	78.00%	78.00%	78.51%	82.00%
E.M.13g	Number of attendances in A&E over 12 hours	Count	394	655	469	423	394	606	527	494	571	572	474	431

ICB and external

Emergency Preparedness, Operational Resilience and Site Leadership Arrangements

Emergency Preparedness, Resilience & Response (EPRR)

Emergency Preparedness, Resilience and Response (EPRR) arrangements have been reviewed as part of winter preparedness planning. This includes a comprehensive review of the Trust's Mass Casualty Plan and associated action cards to ensure they remain current, robust and aligned with national guidance and local operational requirements. Any required updates have been incorporated, and staff will continue to be supported through ongoing awareness, training and exercising to maintain readiness for responding effectively to major incidents and periods of increased system pressure throughout the winter period. Since last winter, the EPRR team have relocated and are now co-located with Site Operations which has significantly improved information sharing and joint working. The Trust's EPRR Lead is a member of the Winter Planning Group.

Adverse Weather Conditions

The Trust receives warnings of adverse weather from the Met Office and heat-health alerts from the UKHSA. The Trust also receives more detailed, local information from the Met Office Advisor via the Local Resilience Forum if forecast weather has the potential to cause disruption. The Trust has an Adverse Weather Plan which can be found on the EPRR page of the Trust intranet and covers all types of weather including heatwave and snow/ice.

The plan is reviewed each year against national guidance to ensure alignment with the UKHSA Adverse Weather and Health Plan. Weather warnings are also shared with key staff, so operational planning can be in line with weather risks. An MoU is in place with Devon and Cornwall 4x4 Response in the event adverse weather causes significant disruption to travel.

Industrial Action Preparedness

The Trust has reviewed industrial action contingency arrangements as part of winter preparedness planning.

Learning from previous periods of industrial action has been incorporated into workforce planning, operational escalation processes and business continuity arrangements. Plans include identification of critical services, staffing prioritisation arrangements, executive command structures, communication processes and escalation procedures.

Should industrial action occur during the winter period, the Trust's Industrial Action Patient Safety Committee will be established to manage and coordinate the period of action, and business continuity plans will be activated to support the continued delivery of safe and effective patient care.

Site Operations

Responsibility for maintaining patient safety, operational flow, and overall site management across the Trust rests with the Head of Operations, with executive accountability held by the Chief Operating Officer during core working hours. Outside of core hours, executive accountability transfers to the Director on Call, who is supported by the Head of Site Operations, On-Call Manager, and Clinical Site Managers. This robust leadership and escalation structure ensures continuous oversight, timely decision-making, and effective management of operational pressures, enabling the Trust to maintain safe, effective services throughout periods of increased demand, including the winter period.

To strengthen operational leadership, oversight and responsiveness during the winter period, the Trust-wide Site Operations Team will move to provide an enhanced seven-day service from 08:00 to 20:30 from January 2027. This function will be delivered by the Head of Site Operations and Head of Operations, ensuring experienced senior operational leaders are available on site every day to provide visible leadership, support timely decision-making, and coordinate the management of operational pressures across the organisation. Supporting our 24/7 Clinical Site Managers and wider Site Operations team.

Outside of these hours, the On-Call Manager, supported through the established executive on-call arrangements, will continue to provide leadership and operational oversight, ensuring seamless 24-hour operational cover throughout the winter period.
This enhanced operational model has been designed to deliver a number of key benefits:

- **Consistent senior leadership and decision-making** – ensuring experienced operational leaders are readily accessible to support frontline teams and respond promptly to emerging challenges.
- **Improved operational coordination and efficiency** – enabling faster escalation, resolution of issues, and strengthened collaboration across services within the Integrated Care Organisation (ICO).
- **Enhanced patient safety and flow management** – providing dedicated leadership to oversee site capacity, demand management, discharge processes and escalation activity.
- **Visible support for frontline teams** – offering a clear and accessible point of contact for operational, safety and flow concerns, whilst maintaining a strong leadership presence across clinical areas.

NHS Devon System Coordination and Mutual Aid

The Head of Site Operations during working hours, and the On-Call Manager outside of these hours, will participate in the NHS Devon ICB System calls throughout the winter period. These calls provide a structured forum for the Trust and our system partners to share real-time information on capacity, demand, patient flow, operational risks and escalation status across Devon, including mutual aid requests.

Participation in the system call enables the Trust to escalate emerging risks, request support, coordinate operational responses and contribute to whole-system decision-making during periods of increased pressure. It also provides NHS Devon ICB and NHSE colleagues with oversight of actions to address congestion, ambulance handover delays, discharge challenges and other flow-related pressures including mental health delays.

Mutual aid arrangements will continue with the current established process across Devon, provider-to-provider, ICB and regional escalation routes where required.

Discharge Coordination and workforce

In line with the NHS England Model Discharge Pathway, the Trust will continue to have a discharge coordinator available on the acute site each day to provide visible support for discharge planning, ward teams and patients. Daily weekday cover will also be maintained across all acute and community wards, supporting consistent discharge oversight and earlier identification of patients requiring pathway planning. The role supports early identification of discharge barriers, promotes expected date of discharge, completes necessary referrals and ensures timely escalation of issues affecting flow. The discharge coordinator will work alongside clinical teams, site operations, patient transport, community services and private providers to support a Home First approach and enable timely, safe discharge through the most appropriate pathway. Community Hospitals will continue to in-reach to the acute discharge coordinator at weekends as required, supporting continuity of discharge oversight across acute and community pathways.

Length of Stay Programme

The Trust will refocus its weekly Length of Stay (LOS) programme on exceptions, unresolved barriers and system issues rather than reviewing every patient who has stayed more than seven days. Individual patient management will remain the responsibility of ward multidisciplinary teams through reliable implementation of SAFER and effective daily board rounds, including senior clinical review, an Expected Date of Discharge agreed within 24 hours and reviewed each day, discharge planning from admission, early engagement with patients, families, community services, equipment and transport, and active identification of next-day and pre-midday discharge opportunities. Board rounds will be action-focused, confirming why each patient remains in hospital, whether they are medically optimised, what needs to happen next, who owns each action and why discharge home cannot occur that day, with early intervention where a stay is becoming prolonged.

The weekly LOS review will therefore receive concise exception reports for patients staying more than 21 days, medically optimised patients who remain in hospital, and significant safeguarding, housing, social-care, legal or system barriers, while also identifying Trust-wide themes requiring escalation. Delivery and impact will be monitored through average length of stay, the number of patients staying more than 21 days, excess bed days, medically optimised patients awaiting discharge, EDD compliance, discharges before midday and weekend discharge performance.

Safety and Flow Meetings

The Trust's Safety and Flow Meetings remain a key component of the winter resilience, providing structured oversight of patient safety, operational pressures, capacity and demand across the organisation. Meetings are held via Microsoft Teams, with participants encouraged to attend in person where possible from the Site Operations Centre / Incident Command Centre (Level 4, Yellow Zone, Torbay Hospital).

Meetings take place at 08:45, 12:00, 15:30, 20:00 and 22:00, with additional ad hoc meetings convened as required in response to emerging operational pressures or patient safety concerns.

The purpose of these meetings is to provide real-time situational awareness and ensure the organisation is well positioned to anticipate, escalate and respond to operational challenges. The meetings support resilience across all patient pathways, including urgent and emergency care, inpatient services, elective care and community services, ensuring a coordinated, organisation-wide approach to managing demand and maintaining patient safety.

Actions agreed during each meeting are documented and monitored through subsequent meetings to ensure delivery, maintain accountability and support a proactive approach to patient flow, capacity management and the safe delivery of services throughout the winter period.

In periods of Opel 4 or any form of business continuity incident or major incident, the leadership of these processes will escalate to the Head of Operations and/or Deputy Chief Operating Officer with delegated authority from the Chief Operating Officer.

Single Point of Contact (SPoC)

The effectiveness of the current Single Point of Contact (SPoC) model delivered Monday to Friday in core hours has been reviewed as part of winter planning. The SPoC function will continue to be the initial point of coordination for requests, ensuring issues are directed to the most appropriate clinical or operational decision-maker at the earliest opportunity. This will help distinguish between matters requiring immediate clinical leadership, operational escalation, discharge support or onward referral to specialist teams. Streamlining escalation processes through a clearer operational route involving designated clinical leaders will improve decision-making, reduce unnecessary hand-offs and ensure timely responses to emerging operational pressures. The model will also support earlier identification of themes, risks and repeat escalation points, enabling proactive intervention and better alignment with safety and flow meetings throughout the winter period.

Operational Surge, Flow and Escalation

The Trust manages periods of heightened demand and challenges associated with balancing inpatient capacity through its Operational Surge, Flow and Escalation Policy. This policy provides the framework for the organisation’s response to escalating operational pressures and incorporates key processes including the Timely Handover Process (THP45), Your Next Patient (YNP) methodology, Full Hospital/Surge Capacity arrangements, and the Super Surge escalation framework. The policy is reviewed and updated regularly to reflect changes in patient pathways, service delivery models, operational processes and estate developments, ensuring it remains effective and aligned with organisational needs. The most current version of the policy is available to all staff via the Trust intranet and serves as the primary reference document for managing patient flow, capacity constraints and surge pressures across the organisation.

OPEL Policy

This plan has been updated to reflect the current national framework and has been adapted to incorporate locally agreed triggers, actions and escalation arrangements. It should be read in conjunction with the NHS England Integrated Operational Pressures Escalation Levels (OPEL) Framework 2024 to 2026 and the NHSE EPRR Framework. The OPEL and EPRR frameworks are complementary but not interchangeable; both may be implemented in parallel, for example where an incident is declared under EPRR arrangements at any OPEL level. Any future changes to national guidance, including updates to the OPEL or EPRR frameworks, will prompt a review and, where required, a further update to the plan.

On-Call Manager

The Trust operates a rotational on-call management rota to provide senior operational oversight, decision-making and support for the safe and effective running of the organisation out of hours. During each duty period, the On-Call Manager maintains awareness of current access, capacity and operational pressures and remains contactable at all times. They respond promptly to issues escalated by the Site Management Team or Switchboard, determining whether these can be resolved remotely or require on-site attendance. The role includes making timely decisions to support patient safety, operational flow and delivery of key performance standards. Where required, the On-Call Manager will liaise with system or regional NHS colleagues and escalate to the Director on Call for matters requiring higher-level authority. All key decisions must be recorded in the On-Call Manager log to maintain a clear audit trail.

On-Call Director

The Trust operates a rotational on-call director rota that covers a 24 hour period. The On-Call Director provides executive/director leadership and senior decision-making during the on-call period, ensuring the Trust continues to operate safely, effectively and efficiently out of hours. The On-Call Director always remains contactable by mobile or landline and acts as the senior point of escalation for issues that exceed the authority, remit or risk appetite of the On-Call Manager.

The role is primarily strategic, providing oversight, authorisation and direction in response to critical incidents, major operational challenges, sustained escalation, business continuity issues and system-level pressures. The On-Call Director supports the organisation to balance patient safety, operational flow, workforce resilience and reputational risk, and will liaise with executive colleagues, system partners and regional NHS teams where required.

Patient Transport Services

Patient Transport Services will play a key role in supporting flow during the winter period. In response to increased demand, capacity will be maximised through the deployment of additional shifts, with a particular focus on later operating hours to support discharge activity and maintain service coverage. The service has flexibility to request overtime and additional shifts from substantive staff, supplemented where possible by a limited pool of bank staff. Private ambulance provision can also be arranged in advance or on the day of need; however, this capacity is limited and may not always provide the same responsiveness or efficiency as the Trust’s own fleet.

A significant operational challenge remains the limited level of advance booking for inpatient discharges. Fewer than 10% of inpatient discharge journeys are currently booked in advance, with most pre-booked activity originating from community hospitals. This limits the ability to plan capacity effectively and can result in short-

notice demand on the day of discharge. Complex discharges add further pressure, particularly where up to three crews may be required at short notice on the same day. In addition, approximately 35% of discharges require a specific timed collection, reducing scheduling flexibility and increasing the risk of delays.

Benchmarking with neighbouring providers highlights the opportunity for improvement. Devon partner organisations achieve significantly higher levels of advance transport booking and have fewer same-day complex or bariatric transfers. Improving earlier discharge planning and transport booking at ward level will therefore be essential to increasing resilience, reducing same-day operational pressure and supporting timely patient flow throughout winter. The service will continue to work collaboratively with ward teams to manage fluctuations in demand and ensure patient transport capacity is used as effectively as possible.

Workforce resilience

Nursing Staffing

The Trust has well-established processes in place to support safe staffing and workforce resilience throughout periods of increased operational pressure, including winter. Nursing staffing is reviewed through twice-daily staffing meetings which provide real-time oversight of workforce availability, patient acuity and dependency, escalation capacity, patient flow, and emerging workforce risks. These meetings operate against agreed nurse-to-patient ratios, normal staffing requirements, and minimum safe staffing thresholds for each clinical area, enabling timely review of staffing risks and implementation of mitigating actions when required. A clear escalation process is in place where staffing levels fall below agreed requirements. Staffing risks are assessed against patient acuity, dependency, enhanced care requirements, and operational pressures to ensure resources are prioritised appropriately and patient safety is maintained. Bank staffing is utilised wherever possible with agency staffing used only where required to mitigate patient safety risks or maintain service continuity. All agency requests are subject to Care Group Director of Nursing oversight and approval, ensuring utilisation is clinically justified and aligned to agreed financial controls.

The Trust's approach is supported by nationally recognised and evidence-based staffing methodologies, including the Safer Nursing Care Tool (SNCT) and Community Nursing Safer Staffing Tool (CNSST). These tools provide an objective assessment of patient acuity and dependency and are used alongside workforce, quality, and operational metrics to support establishment reviews and workforce planning. Staffing recommendations are not based solely on tool outputs and are triangulated with professional judgement, workforce indicators, patient safety metrics, and operational intelligence. Professional judgement meetings form a key component of the Trust's safer staffing governance framework. These multidisciplinary meetings provide an opportunity to challenge and validate staffing establishments by considering workforce pressures, recruitment and retention challenges, sickness absence, temporary staffing utilisation, patient harms, incidents, patient experience, and staff wellbeing. This ensures workforce decisions

reflect both the quantitative data and the operational realities of each clinical area. Quality and safety indicators are routinely reviewed alongside workforce metrics to understand the relationship between staffing levels and patient outcomes. This includes falls, pressure ulcers, medication incidents, patient deterioration, enhanced observation requirements, complaints, staffing incidents, and patient experience measures. Reviewing these measures through the professional judgement process supports a comprehensive assessment of service risk and provides assurance that workforce decisions remain focused on the delivery of safe, effective care.

Operational oversight of temporary staffing is provided through the SCOPE (Staffing, Capacity, Oversight, Performance and Efficiency) Group, which reviews workforce availability, roster performance, fill rates, temporary staffing utilisation, vacancies, sickness, and financial performance. Reliance on temporary staffing and associated expenditure is reviewed weekly by senior nursing leaders to ensure appropriate challenge, accountability, and delivery of agreed reduction plans. Additional strategic oversight is provided through the Nursing, Midwifery and Allied Health Professional (NMAHP) Workforce and Professional Development Group. The group monitors workforce performance, recruitment, retention, vacancy management, and workforce sustainability and provides assurance regarding delivery of workforce objectives. Temporary staffing reliance, associated expenditure, recruitment pipelines, and vacancy trajectories are reviewed routinely, ensuring workforce risks are identified and mitigating actions implemented where required.

A key focus of the Trust's winter workforce strategy is reducing reliance on bank and agency staffing through substantive recruitment, retention initiatives, improved roster management, and workforce planning. Temporary staffing remains an important mitigation during periods of increased demand; however, usage is closely monitored through daily staffing reviews, professional judgement meetings, SCOPE and NMAHP governance arrangements, and Director of Nursing oversight. This supports delivery of safe staffing whilst reducing agency expenditure and improving workforce sustainability.
Corporate oversight is maintained through regular safer staffing reporting and established governance structures, enabling ongoing review of staffing establishments, workforce performance, patient safety indicators, and temporary staffing utilisation. The Trust also undertakes regular safer staffing census periods, providing a longitudinal assessment of service demand, patient acuity, workforce pressures, and quality outcomes. This ensures staffing establishments and workforce plans reflect seasonal variation and support an evidence-based approach to workforce investment and winter resilience planning. Collectively, these arrangements provide assurance that workforce risks are proactively identified, escalated, and managed through clearly defined staffing ratios, minimum staffing thresholds, twice-daily staffing reviews, professional judgement, Director of Nursing oversight, and weekly scrutiny of temporary staffing utilisation and expenditure. This supports the delivery of safe, high-quality care whilst maintaining workforce sustainability and financial stewardship throughout periods of increased demand.

Medical Staffing

A review of resident doctor rotas identified opportunities to improve doctor wellbeing, strengthen resilience and support earlier patient discharge ahead of winter.

SHO Rota

- Twilight shifts have been removed. SHOs now undertake three principal out-of-hours shift types: Nights, Clerking Days and Ambulatory Clerking.
- The rota has been redesigned to provide greater spacing between out-of-hours duties, improving rest periods, annual leave opportunities and continuity of daytime clinical work.
- Increased daytime staffing is expected to support ward processes and contribute to reductions in length of stay.

Foundation Year 1 Rota

- Ambulatory shifts have been removed. F1 doctors now undertake Nights, Clerking Days and Twilight shifts.
- Improved spacing between on-call duties enhances rest periods and continuity within clinical placements.
- Increased daytime cover improves access to teaching opportunities and team consistency.
- Weekend ambulatory shifts have been replaced with standard-hours clerking shifts, maintaining clerking experience while increasing morning clerking capacity to support weekend patient flow.

Additional Support

- Through workforce redesign and budget management, an additional 1.0 WTE Locally Employed Doctor (LED) has been secured for Acute Medicine. This increases rota resilience, reduces pressure on trainees and provides greater flexibility to manage unplanned absence.
- Changes to registrar weekend working have enabled substantive cover for the weekend discharge senior doctor role, reducing reliance on locums, improving continuity and supporting higher weekend discharge rates.

OT/PT Workforce

Allied Health Professional services will play a key role in supporting winter resilience, admission avoidance, discharge flow and the reduction of corridor care. The Joint Emergency Team (JET) provides a same-day admission avoidance service across the Emergency Department and Acute Medical Unit, with current staffing including Occupational Therapy, nursing and discharge coordination support. The team will also support patients in escalation areas, including areas such as Broadsands and the discharge lounge when these are being used for escalation capacity. Where patients are already known to ward-based therapists, therapy teams will continue to review patients in the discharge lounge where required, particularly where there has been deterioration or where continuity of assessment and discharge planning is needed.

The JET service currently operates Monday to Friday from 08:00 to 16:00, with late cover until 18:00 supported by the wider inpatient therapy team, and weekend cover from 08:00 to 16:00. Referrals into the service are made through orders placed to JET. E4 and McCallum are co-managed by inpatient therapy and JET, with therapy

cover provided from 08:00 to 16:00 Monday to Friday and an urgent assessment and discharge service available at weekends. Orders for these areas should be placed to Occupational Therapy or Physiotherapy as appropriate.

For winter, the JET model has been strengthened through the appointment of a dedicated Physiotherapist who will work alongside the team in ED and AMU, while also supporting E4 and McCallum alongside existing Physiotherapy cover. Where capacity allows, this role will support deconditioning avoidance through earlier assessment, mobilisation and discharge planning within AMU. This represents an important development in supporting admission avoidance, earlier discharge decision-making and improved flow from the front door.

The JET service is also subject to review as part of the Trust's corridor care reduction programme. This review will consider opportunities to adapt hours of operation, improve responsiveness and strengthen support to key front-door and escalation areas. Any extension or change in service provision will require additional investment, as current resource is already stretched and would not be sufficient to deliver an expanded model without affecting existing inpatient therapy capacity.

Inpatient Physiotherapy services operate core hours seven days a week from 08:00 to 16:00. Weekend provision is delivered as a reduced service, focused on urgent priorities including discharge, respiratory care and time-critical assessment. New patient assessments and ongoing rehabilitation are completed at weekends where capacity allows. Inpatient Occupational Therapy services also operate seven days a week from 08:00 to 16:00, with weekend provision focused primarily on supporting discharges. During winter, any long-term vacancies or sickness absence within AHP services will require bank or agency cover to minimise the impact on patient flow, discharge performance and admission avoidance.

Occupational Therapy teams are currently focusing on improvement projects that enable earlier intervention in the patient journey, aligned to the wider JET and admission avoidance work. Physiotherapy teams are focusing on improving morning efficiency, increasing early mobilisation and taking a more active role in discharge planning, rather than discharge planning being seen primarily as an Occupational Therapy function. These changes are intended to support earlier decision-making, reduce delays, prevent deconditioning and contribute to improved flow across urgent, acute and inpatient pathways throughout the winter period.

Winter Vaccination programme 2026-27

The NHSE states that all trusts must have an accessible occupational health offer for staff which is available throughout the entire flu campaign. This must include onsite bookable appointments and walk in appointments. All trusts must have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, including a stretch target for increasing the percentage of staff vaccinated in 2026/27. The plan should include:

- Improved communications and engagement with staff to increase their vaccination rates and to support the promotion of vaccination to eligible patients, better highlighting the link with winter pressures Urgent and Emergency care plan 2026/2027
- Work with sector partners to proactively promote available vaccination offers to those who provide and draw on care
- A requirement for NHS hospitals to offer vaccination on discharge to any patients going into a care home

Table 3 below demonstrates the Trust's 25/26 vaccination position for flu vaccines in relation to other providers in the system, as well as against regional and national aggregated position.

In last year's vaccination campaign, the Trust recorded the best position for vaccination in the Devon system and also exceeded the regional and national average positions for flu with 57.54 % of the frontline workforce being vaccinated.

Table 3. Frontline staffing vaccination data 24/25 campaign

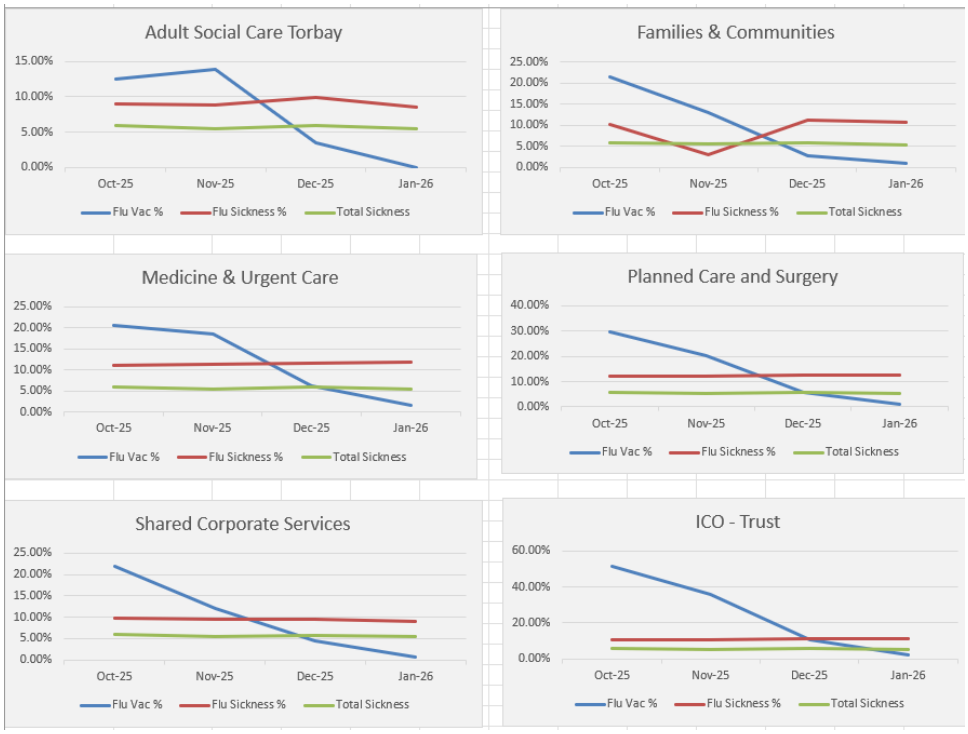
Regional Flu Vaccinations (frontline staff)

FLU - Devon Frontline Healthcare Workers uptake % to date All Trusts have a target to exceed 24/25 uptake by at least 5%	Uptake by Trust							
	DPT		RDUH		TSDFT		UHP	
24/25 end of campaign uptake %	48.00%		47.40%		50.90%		45.70%	
Staff on ESR	4,265		13,448		6,567		10,309	
FLHW on ESR	3,090		10,409		4,918		7,480	
25/26 Uptake to date %	No. of vaccs	Uptake %	No. of vaccs	Uptake %	No. of vaccs	Uptake %	No. of vaccs	Uptake %
	1,559	50.45%	5,825	55.96%	2,830	57.54%	4,297	57.48%

Graph 1 demonstrates the Trust's position between October 2025 and January 2026 and the breakdown of sickness at care group level with a further breakdown of flu specific sickness as a proportion of total sickness.

Analysis of the 2025/26 campaign demonstrates strong organisational engagement and provides a solid foundation from which to deliver further improvements in 2026/27.

Graph 1. Trust and care group flu vaccination data 25-26



To continue to drive improvement the trust will aim for a 2.5% increase in flu vaccinations provided to frontline staff across the organisation however this will be dependant upon NHSE review.

Graph 1 demonstrates the Trust's vaccination position between October 2025 and January 2026 and provides a comparison between vaccination uptake and sickness absence at Care Group level. The data highlights the impact seasonal respiratory illness can have on workforce resilience and reinforces the importance of maximising vaccination uptake across the organisation.

The national flu immunisation programme letter stated that flu vaccinations for 2026/2027 will be undertaken as follows

- Pregnant women and all eligible children will start from **1st September 2026**.
- All other adult flu cohorts will start from **1 October 2026** and will run until the **31 March 2027**.
- Although, we anticipate that the majority of vaccinations should be completed by the **end of December 2026** to provide the best possible protection going into winter.

The COVID-19 programme will run from **1 October 2026 to 31 January 2027**.

NHS England has acknowledged the differences in cohorts for Covid-19 and Flu however, would encourage co-administration where possible for the following cohorts:

- Adults aged 75 years and over
- Residents in a care home for older adults
- Individuals aged 6 months and over who are immunosuppressed.

The Trust winter vaccination programme 26-27 will be led by the Deputy Chief Nurse with support from the Associate Director of Nursing and Professional Practice (ADNPP) for IPC, to ensure trust wide oversight.

To enable the delivery of the internal vaccination programme, a working group will be convened in August 26 to work up the plan. This will include a dedicated vaccination team which is in place, and a number of peer vaccinators

For the peer vaccinators a request will be made for each care group, via the ADNPP's, to identify staff members who will enable effective vaccination roll out within their care group by end of August 26. Vaccination training will be given in September with the vaccinators starting local vaccinations from 1st October.

Following learning from winter 25-26 the model of delivery for staff and patients will be replicated for the 26-27 programme consisting of;

- Patients – eligible patients will receive vaccinations from Ward based vaccinators as identified by ADNPP's/Matrons/Ward Managers who's stay has been > 7days and are medically stable. This will be supported by senior vaccination team members.
- Weekly length of stay reviews to incorporate those eligible.
- Patients attending outpatients in relation to high-risk groups whom meet the criteria for vaccinations will be offered at the point of contact.

- Staff:
    - Ward based vaccinators will offer vaccinations on a daily basis with trust wide support to ensure delivery of vaccines across acute site
    - Booked and Drop in clinics will be held daily in the Bay View vaccination Hub, led by a group of dedicated vaccinators
    - Senior Nurses to support with peer vaccinators in the community, supported by roving vaccinators
    - Advertised planned sessions in all locations of the Trust including all off site locations, Estates and Catering
    - Nighttime vaccinations
    - Communication Strategy to support, raise awareness

The Trust vaccination programme will be conducted between Wednesday 1st October and Friday 19th December 2026 with a reduced offer over January 2027. It will be administered predominantly from the Bayview Balcony between 8am and 8pm on these days, initially 7 days per week and then reducing to 5 days per week. An alternative plan to increase vaccination uptake within our community settings will also be created to prevent the need for these staff groups to travel to the main hospital site to receive their vaccination.

Our primary goal is to increase staff flu vaccination uptake across the Trust, with particular focus on frontline staff to help protect patients and the immunosuppressed to help reduce the sickness spike we experience around Christmas and New Year period.

"Protecting our patients starts with protecting ourselves" campaign should emphasise clinical leadership, peer influence, and accessibility whilst addressing vaccination hesitancy through myth-busting and positive messaging and asking medical staff to remember why they joined the NHS in the first place; to help patients and protect others.

Key tools and areas to focus on include:

Communications Channels

- Trust Talk
- ICONews
- Screensavers
- Intranet
- Video messages

Behaviour Change Approach

- Myth-busting
- Peer champions
- Senior clinical leadership
- Ward-based conversations
- Visibility campaigns

To ensure a robust and ongoing evaluation of the Trust's vaccination programme, the following internal governance structure has been created. This will enable the Trust to identify any issues with previously identified challenges such as suitable levels of vaccine supply, recording of data, robust coverage of vaccinators to enable provision to staff working unsociable shift patterns. The governance structure designed includes

- Flu & Covid Vaccination Working Group Meeting (will move to weekly when programme launched)

- Monthly reports submitted to:
    - Safety Quality Assurance Group (SQAG),
    - IPC governance (IPCG),
    - Health and Safety Group
    - Finance and Operations Committee

Infection Control

- Daily monitoring of IPC related incidents and complaints with appropriate action taken by IPC Associate Director of Nursing and Professional Practice (ADNPP)
- Biweekly Governance meetings to review all IPC related incidents and discuss actions required
- Weekly meetings with Microbiologist to review all Blood Bourne Infections to determine if further review/actions are required.

Facilities

The trust's high level of cleanliness has continued into 2025-2026 where protocols have been adapted to meet the needs and demands of the clinical teams.

Compliance with the national cleaning standards introduced in 2021 has been maintained. Coupled with weekly reactive cleans on floors, walls and beds in all areas, the hotel service staff have continued to keep all wards and departments to a high standard of cleanliness. Any areas that have not met standard through auditing or visual inspection, have gone through the rectification timeframe and re-audited to meet standards expected. It has also been the third year with the new cleaning standards and going from a percentage score to a score rating from 1 – 5 with 5 being very good. Functional areas achieving 4 score-rating or below will generate remedial actions to improve. In these instances, the activity generated through rectification will serve as a training opportunity going forward and to enhance the focus in all areas to provide assurance.

Deep Cleans

Work has been undertaken over the last year to develop a joint IPC/facilities cleaning audit programme to be able to provide assurance across the trust. In 26/27 this will be supported by of a new education programme for both facilities and other relevant staff across both acute and community settings

The trust provides two type of Deep Cleaning services: Hydrogen Peroxide Vapour treatment (HPV's), which is the recognised Standard of deep cleaning, with the addition of Ultraviolet Cleaning (UVC) in May 2024, which was added to improve the speed of the deep cleans and provides the same standard of cleaning for difficult areas to access. During the summer months particularly August/September there was a higher failure rate with HPV's due to the humidity recognising that HPV

machines needed an operating temperature to be below 26 °C to work. With the agreement of IPC and the DIPC, a double deep clean was the fall-back alternative when this occurred.

The number of deep cleans undertaken in 2025/2026 was 11137 a decrease of 3558 from 2024/2025 this is as a result of continued oversight of the IPC Team and Facilities ensuring appropriate cleans are undertaken to support the health and safety of those in our care.

Table 4: Performance data April 2025 -March 2026

Domain	EFM Services Performance Data March 2026 for April 2026 Report	2025-26 Quarter One			2025-26 Quarter Two			2025-26 Quarter Three			2025-26 Quarter Four		
		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
	Torbay Only - HPV Cleans per month	32	35	26	25	22	41	17	20	22	13	19	31
	Torbay Only - UVC Cleans per month	1	0	2	1	10	3	0	3	0	1	1	10
	Torbay Only - Deep Cleans per month	897	810	797	836	838	731	861	956	1223	994	872	1322

Patient Engagement

There is open and clear communication with patients, carers, family and the wider public, with work being undertaken to provide visible IPC support across in-patient areas and provide an accessible service at the point of patient contact.

There are a variety of patient information leaflets available for the wards to print off on the IPC ICON page, which have been reviewed and updated to reflect local and national guidance

The IPC team continue to communicate and display information about Infection Control Standards, with weekly updates in standard meetings (IPC is referenced in the managers' weekly briefing) posters, screen savers etc as well as website information and the use of social media via the trust.

There is a continuous programme for both staff and patients promoting good hand hygiene. Compliance is monitored on a monthly basis with the 90% target achieved across the 2025/26. This includes support to highlight the 'Gloves off' and the 'Bare below the elbow' initiative to improve IPC compliance. This enables the IPC team to reach out to a significant number of staff and relatives trust wide, spreading the importance of glove usage in the prevention of infection and becoming a greener, more sustainable organisation.

Patient flow, Identification and Prevention of Transmission

With the increasing pressure on the trusts urgent and emergency pathways, there has been a review across the whole organisation on responding to Operational Pressure Escalation Levels (OPEL) status and bed pressures. There are acknowledged risks which recognise the harm that can be sustained from a patient perspective both whilst waiting for an ambulance and waiting in an ambulance due to capacity /flow issues.

In response to these risks and pressures, the IPC team has looked at ways to maintain patient safety and assist the flow of patients, and these will be continued over the winter of 2026/2027:

- Daily IPC representation at all patient flow meeting
- Daily Flow/Outbreak meetings when required Chaired by IPC Director of IPC (DIPC)/ Deputy DIPC/ ADNPP Lead. This will also cover all patient cohorts (including escalation space) and will be business as usual through a risk-based approach.
- Daily review of EPIC by IPC team to identify any high-risk patients/alerts
- Placement of medical patients in surgical wards. With appropriate risk assessments done by nursing staff patients can be cared for in different clinical environments which supports flow of patients out of ED if all beds are being utilised
- Use of side rooms - supporting ward nurses to review if the patient with an Infection needs to be isolated e.g. if after 48 hours of appropriate antibiotics and with appropriate risk assessment a patient can come out of a side room
- 7-day IPC cover across core hours to support with decision making and flow
- Introduction of EPIC in April 26 allows for real time feedback and therefore reduces any delays in intervention

The IPC team works closely with wards, operational site teams, and housekeeping teams, to ensure patients with infection are rapidly identified and isolated correctly with additional cleaning in place as required. This close working enables efficient responses to outbreaks to limit spread through standard work and precaution usage.

Mandatory training at trust induction continues to include IPC as core requirements. This is being monitored via relevant Governance groups and led by Mandatory Learning Oversight Group (MLOG)

Hand Hygiene

Hand hygiene compliance was reviewed and as the benchmark across neighbouring organisations was set at 90% compliance the DIPC supported the change to this level within TSDFT to ensure accurate benchmarking.

It is important to get our fundamentals of care right, and audit results have been consistently above 90% following the implementation of the hand hygiene road show and review of how audits were being undertaken to ensure consistency in completion.

Robust data supports quality improvement work and aids the IPC team to focus and respond targeted work to improve hand hygiene. There are areas where hand hygiene is particularly low, and these have been targeted to support improvement. The IPC team has provided targeted interventions as required to wards which has included:

- Turbo training- an informative 10-minute theory burst to support staff in making hand hygiene a habit.
- Glow box training- a physical demonstration of how easy it is to spread an unseen hazard around a clinical environment alongside the effectiveness of good hand washing to remove this.
- Implementation of an IPC Link Nurse programme, to reinvigorated roles and responsibilities in clinical practice, will be developed over 2026/2027 to redefine roles and responsibilities following the introduction for the Electronic Patient Record (EPIC)

Side Rooms

Isolation for infection prevention reasons means caring for a patient in a single room, preferably with ensuite toilet and washing facilities. Only 30% of the inpatient beds on the Torbay Hospital site are single rooms with an average of 30% of these rooms being used for IPC related isolation. Most beds across the acute hospital site are in bays of 4-6 people. The side room capacity is higher in the community hospitals; Newton Abbot, Dawlish, and Totnes and Brixham. To ensure appropriate monitoring, and use of side rooms the IPC team will continue to monitor usage via the EPR system introduced in April 26.

Fit Testing & PPE

Fit testing arrangements are in place for staff required to utilise respiratory protective equipment and records are maintained in accordance with Trust policy. Additional fit-testing capacity can be mobilised during periods of increased demand to support outbreak response and escalation arrangements.

The Trust maintains robust PPE stock management processes, including routine monitoring of stock levels, supply chain resilience arrangements and escalation procedures to mitigate supply disruption. PPE availability is reviewed through established operational and IPC governance arrangements throughout the winter period.

Infection Prevention and Control (IPC) Winter plan 2026-2027

- The IPC team provide a seven-day service to ensure a robust and timely response to any IPC issues across the trust footprint from an acute and community perspective.
- The trust's clinical microbiologists support the team in all aspects of IPC and takes over IPC On-call cover out of regular working hours. This support also includes outbreak management, surveillance, for and management of healthcare associated infections (HCAI's), and provision to primary and secondary care.
- The IPC team meet daily to review new clinical cases / situations in order to prioritise the workload.
- A IPC Single Point of Contact (SPOC) is identified to ensure continuity throughout the winter period.
- Daily review via EPIC of side room usage and availability providing IPC oversite across all in-patient areas.
- The IPC team monitor all IPC patient alerts with advice being given as required to support correct IPC interventions.
- Weekly IPC meetings are diarised with an open invitation to support care group attendance to discuss compliance with IPC and raise any issues in a timely manner.
- Weekly meeting with facilities and housekeeping are diarised to support and discuss any issues.
- Daily outbreak/flow meetings are initiated as required with relevant MDT member invited to support the safety of all patients across in-patient settings
- Monthly IPCG meetings are held to enable discussion re any trust wide learning form pressures due to Winter escalation from an IPC perspective
- Bi- Weekly meetings with Governance coordinators for Planned Care, Medicine and Communities and Families are held to monitor trends and themes across the trust footprint.
- The Community Infection Management Service (CIMS) meets weekly with both Torbay and South Devon Quality Assurance and Improvement teams (QAIT)
- Visible and accessible IPC Team out in clinical areas providing education and support

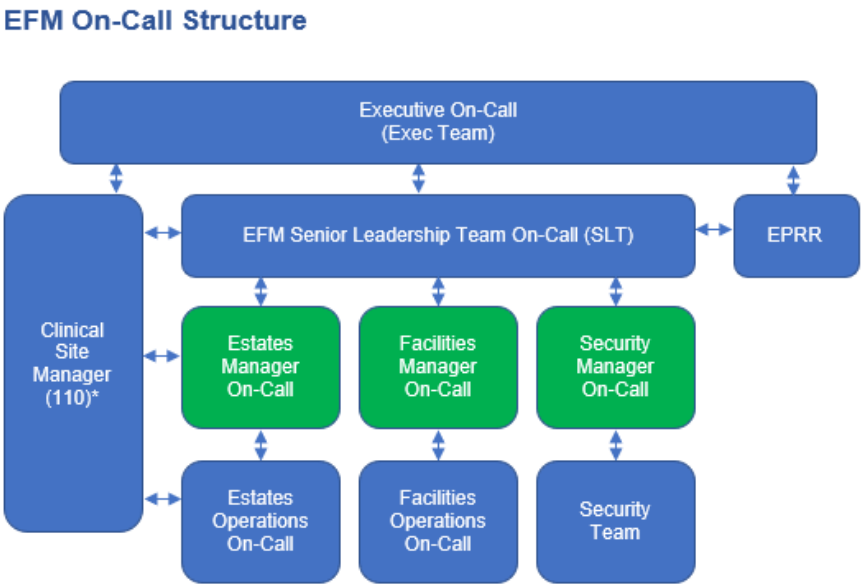
Group	Frequency	Purpose
Flu & Covid Working Group	Weekly during campaign	Operational oversight
IPC Governance Group	Monthly	Performance assurance

SQAG	Monthly	Quality oversight
Finance & Operations Committee	Monthly	Executive assurance

Through this governance framework, issues are identified and worked upon both proactively and reactively, coordinating actions between multiple parties to reduce infections and improve standards. The reporting framework ensures oversight and insights into variations in practice, with a focus on hotspots requiring targeted action

Estates and facilities – including community

Estates and facilities plans and escalation processes are contained within the Estates & Facilities on call and Incident Handbook. This document was last updated in January 2026.



Estates & Facilities Senior Leadership (SLT) on-call team: this team will manage the communications to the above teams and will provide any support required by the Estates Manager on-call or the on-site Facilities Managers. They are also part of the Incident Response Team **(Tactical)** and will act when called upon.

Estates Manager on-call team: the primary role of this team is to provide operational management support to the on-call teams, both 'in-house' and 'outsourced' service providers. They also provide support to the Facilities on-call manager as and when required. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team **(Operational)** and will act when called upon.

Facilities Manager on-site team: the primary role of this team is to provide operational management support to the Facilities Supervisors and Delivery teams, both 'in-house' and 'outsourced' service providers. They also provide support to the Estates on-call manager as and when required. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team **(Operational)** and will act when called upon.

Estates Operational Delivery On-call team: consists of an Electrical and a Mechanical Technician. They have the required knowledge to address and make safe any part of the Estates infrastructure. They are informed of when a task is required to be escalated and the procedures in place to follow. They have the authority to call specialist contractors for advice or assistance. This team is the 'first response' to the Acute site and are called via the central helpdesk on 01803 654426. The Clinical Site Manager or Switchboard will call them out of hours to report faults. If not available the Estates on-call Manager is there as escalation.

Community Maintenance On-call Provider: the on-call service for the Community Properties is provided by our contracted maintenance provider, on behalf of the Estates Delivery department team, and operate their own 'out of hours' Service desk.

This team is the 'first response' to the Community sites and are currently called from either the affected Site, Clinical Site Manager, Switchboard or the Estates On-call Managers.

There may be occasions that the either the Acute teams or Community on-call teams may be required to attend and assist any property managed by the Trust.

The PFI Hospital (Newton Abbot) operates it own on-call service, with the exception of Medical Gas services. The competent Estates Delivery on-call person may be required to attend these sites and replace the oxygen cylinders.

Security Manager On-call: provides management support to the Security teams, both 'in-house' and 'outsourced' service providers in support of Trust-wide Security Aims and Objectives. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team **(Operational)** and will act when called upon. They can be contacted 24/7 on: 01803 655094.

Specialist Deep Cleaning Services

To support with management of IPC issues through winter, a review of specialist cleaning services has been undertaken to ensure requirements for cleaning do not impact on the flow of the organisation.

The Specialist Deep Cleaning Team operate 24/7 and have specialist deep cleaning team, working through the day and night to meet our Infection Control requirements.

The Specialist Deep Cleaning team, can be contacted via the Helpdesk on 01803 655331. Alternatively, through the 24hr on-site Facilities Manager on 07827 369550 or via Switchboard.

The Specialist Deep Cleaning Team, undertake deep cleaning for infections, such as:

- Covid 19
- Clostridium Difficile
- Norovirus
- D & V
- and other infectious diseases that require deep cleaning or HPV Cleaning.

Maintaining Safe Estate

Any out of hours issues related to the grounds of the acute site issues can be dealt with firstly through the on-site Facilities Manager to make safe out of hours.

In winter, the Grounds & Gardens (G&G) team will be made aware of any weather issues from the Met Office and grit paths. The council will grit main roads during icy conditions. This will happen normally between 1st December until 31st March and the G&G team can be contacted on: 07785 720098 Monday – Friday 08:00-16:00.

The G&G team also have an on-call rota during the winter months which is shared by the whole team. Although on-call team members do not have a work phone, they can be contacted on their personal number.

The spreadsheet for the on-call rota and the personal numbers can be found on the shared drives (HOT_SER, ON CALL, G&G On call).

As part of the Adverse Weather Business Continuity Plan, an assessment will be made on any issues related to the safety of trees on the estate. Any tree issues will be escalated to Teign Trees on:
normal hours Monday – Friday: **01626 773499**
Out of hours - 24hr assistance: **07815 837424**

Our People

The delivery of safe, effective and compassionate care this winter depends on a healthy, supported and resilient workforce. The Trust recognises that winter places additional pressures on services, teams and individuals through increased demand, higher patient acuity, operational escalation and ongoing workforce challenges. Maintaining staff wellbeing is therefore a key component of the Winter Plan and directly supports patient safety, operational resilience and workforce sustainability. The Trust's objective is not only to maintain safe staffing levels, but to ensure colleagues feel supported, valued and able to access the resources they need to remain well at work.

Evidence unequivocally demonstrates that staff wellbeing is intrinsically linked to patient outcomes, quality of care, retention and organisational performance. Mental health conditions, including anxiety, stress and depression, account for a significant proportion of sickness absence and are particularly prevalent within urgent and emergency care environments. Periods of sustained operational pressure, workforce shortages, redeployment and high patient demand can adversely affect morale and wellbeing, increasing the risk of sickness absence, burnout and staff turnover.

This winter also takes place alongside significant organisational transformation, including service redesign and major implementation programmes. The Trust recognises that periods of change can create uncertainty and anxiety for both staff and managers. As a result, additional wellbeing support, communication and development opportunities have been incorporated into winter planning to ensure colleagues are supported to navigate change effectively while maintaining psychological safety, engagement and resilience.

Prioritising Rest, Recovery and Safe Working

Research consistently identifies rest, recovery and effective workload management as essential components of workforce wellbeing. Throughout the winter period, leaders and managers will be expected to actively support breaks, annual leave planning and workload prioritisation to reduce fatigue and maintain safe working practices. The Trust will continue to promote the use of rest facilities and encourage teams to view breaks as a critical patient safety intervention rather than a discretionary activity. Staff fatigue is a recognised patient safety risk and remains a key focus of the Trust's wellbeing strategy.

Managers will be supported to recognise early signs of stress, burnout and fatigue and to take proactive action where concerns arise. This includes wellbeing conversations, early intervention approaches, clear referral pathways and ensuring staff can access support at the earliest opportunity. The Trust will continue to promote psychologically safe environments where colleagues feel comfortable speaking up, seeking help and discussing wellbeing concerns without stigma.

Development, Training and Supervision

Access to learning, development and professional support remains important during periods of operational pressure. The Trust recognises that development opportunities, reflective practice and supervision are important protective factors that support wellbeing, retention and workforce resilience.

During winter 2026/27 the Trust will continue to invest in leadership and management development that supports staff wellbeing, including:

- Training in wellbeing conversations and early intervention.
- Support for managers to identify workplace stressors and workload risks.
- Development in compassionate leadership and psychological safety.

- Education on managing pressure, resilience and responding to distress.
- Guidance to support consistent management practice and policy application.

In addition, the Trust is planning and delivering a proportion of mandatory, statutory and developmental training activity ahead of the winter period wherever possible. This proactive approach aims to reduce training demands during periods of peak operational pressure, maximise workforce availability during winter and ensure compliance with mandatory training requirements is maintained throughout the year.

Targeted development sessions will also be available to support managers and staff in navigating organisational change. These sessions will focus on understanding the impact of change, supporting teams through uncertainty, maintaining wellbeing during transition and strengthening confidence in leading and experiencing change positively.

The Trust remains committed to ensuring colleagues have appropriate access to supervision, reflective practice and peer support opportunities. Team reflection sessions and structured opportunities to discuss challenges, incidents and learning will continue to form a key part of the wellbeing offer, particularly in higher-pressure clinical settings.

Enhanced Wellbeing Support

Alongside the existing wellbeing offer, a comprehensive wellbeing improvement programme is being developed to strengthen support available to colleagues. .

The wider wellbeing programme reinforces the Trust's commitment to creating a compassionate and psychologically safe culture where staff wellbeing is viewed as a fundamental component of delivering safe care rather than an additional activity.

Current wellbeing support available to staff includes:

- Staff support and counselling services.
- Single-session psychological therapy.
- Team reflection and debrief sessions.
- Trauma support following incidents.
- Financial wellbeing guidance and advice.
- Occupational Health support.
- Employee Assistance Programme (EAP).

Strengthening Wellbeing Through Leadership, Communication and Early Intervention

Nursing, operational and corporate leaders will play a key role in reinforcing the wellbeing priorities of the Winter Plan. Leaders will be expected to provide visible and consistent communication regarding the importance of taking breaks, maintaining hydration, accessing supervision, prioritising rest and seeking support early when needed. These messages will be reinforced through team briefings,

safety huddles, leadership walk-rounds and routine communications to ensure colleagues receive consistent messages throughout the winter period.

The Trust is clear that wellbeing is not an optional activity or an individual responsibility alone; it is a fundamental component of safe care delivery. Protected breaks, access to supervision, reflective practice, development opportunities and timely wellbeing support are recognised as essential patient safety measures that help reduce fatigue, improve decision-making, support retention and maintain workforce resilience.

The Trust's position is unequivocal: supporting staff wellbeing is a core element of the Winter Plan and a critical patient safety intervention. Leaders at all levels are expected to actively promote wellbeing, facilitate access to support and create the conditions in which colleagues can work safely, sustainably and compassionately throughout the winter period.

Education and development activity will continue throughout the winter wherever possible. However, should operational pressures require it, established business continuity arrangements will be implemented to support safe service delivery. Following appropriate risk assessment and agreement with clinical leaders, appropriately registered education staff may be supported to work within clinical settings, within their scope of practice and competence, to provide additional capacity and support both patient care and frontline team wellbeing during periods of significant pressure.

Maintaining staff wellbeing through winter requires a whole-system approach. Alongside ensuring safe staffing levels, leaders will actively reinforce expectations around breaks, rest, supervision, development and access to support. Clear and visible communication will ensure colleagues understand that wellbeing forms a central component of the Trust's winter safety plan. Supporting staff to remain well, access help early and work in supportive environments is recognised as fundamental to workforce resilience and the delivery of safe, high-quality patient care.

Monitoring, Escalation and Assurance

The Trust recognises that the effectiveness of the winter wellbeing plan relies on active monitoring, timely escalation and visible leadership oversight. Staff wellbeing will therefore form part of routine operational and workforce governance throughout the winter period, ensuring risks are identified and addressed at the earliest opportunity.

Wellbeing indicators will be routinely reviewed through existing workforce, staffing and operational meetings. This will include consideration of staffing pressures, sickness absence trends, staff fatigue, wellbeing concerns, incidents relating to workforce pressures and any themes emerging from teams. Leaders will be

expected to escalate concerns where staff wellbeing may be impacting on service delivery, patient safety or workforce sustainability.

A specific focus will be placed on monitoring whether staff are able to take protected breaks and access appropriate rest periods during periods of operational pressure. Where teams are unable to achieve this consistently, these issues will be escalated through established staffing and operational processes so that mitigating actions can be considered. The Trust recognises that the ability to take breaks is a key wellbeing and patient safety measure and will seek assurance that this is being actively supported across services.

Attendance at mandatory training, statutory requirements, winter preparedness training and wellbeing development activities will also be monitored throughout the winter period. This will help ensure colleagues continue to meet professional and organisational requirements while enabling the Trust to identify areas where operational pressures may be preventing access to essential learning, supervision or development opportunities. Risks identified through this monitoring process will be escalated through appropriate governance routes.

Wellbeing concerns arising from incidents, patient safety events, violence and aggression, traumatic events, organisational change or other workforce pressures will be reviewed through existing governance arrangements. Learning from incidents and staff feedback will be used to inform wellbeing interventions, communication activity and leadership actions throughout the winter period.

Regular reporting on workforce wellbeing indicators, including sickness absence, training compliance, uptake of wellbeing support, workforce risks and emerging themes, will provide ongoing assurance to leaders and enable early intervention where required. This approach will ensure that staff wellbeing remains a visible and integral component of the Trust's winter safety and resilience arrangements throughout 2026/27

Communications and engagement plan

This is a summary outline plan to provide assurance on our communications and engagement work to support the delivery of our winter plan. A detailed communications and engagement plan will be produced once the winter plan has been signed off.

We will use learning from last winter to create an evidence-based campaign approach to deliver our organisation’s winter objectives:

- Admission avoidance
- Reducing outpatient demand
- Increasing staff vaccination rates

Our winter plan will be implemented from October 2026 to March 2027, with the main activity taking place in October to support staff vaccinations and December and January when there is the greatest level of demand.

We will target messaging and use channels which have been selected to reach their intended audience and achieve the greatest impact. This approach will ensure we minimise confusion and message fatigue during the winter period.

Clinical data and campaign analytics will inform our work to identify and target key groups and communities (such as post codes, interests and social networks and influencers) to help achieve our objectives.

We will continue to test messaging and materials with colleagues to ensure it has the greatest impact.

Content and messaging will be created and tested during August and September, including vaccination champions to ensure it has the greatest impact, and a range of tactics will be used to create a sense of excitement and friendly competition as part of the delivery plans.

We will use a variety of channels including TV, radio and print, social media, digital screens in our hospitals, internal communication channels, while also using community champions and leaders, partner communication channels and established networks to maximise our messaging.

We will use our people and patients in our content to tell our stories for authenticity and to create a community of ownership. We know from previous campaigns that people respond to faces and voices they recognise from their own community, rather than stock images.

Collaboration

Effective communications protocols are in place between key partners in Devon's NHS and local authorities to ensure a consistent approach to our winter messaging and responding to incidents and pressures, including critical incidents.

We will continue to adopt a One Devon approach to develop and deliver our winter campaigns, working in partnership with colleagues at NHS Devon, NHS trusts, NHS England, local authorities and Healthwatch. This will include agreeing key messages and campaign materials for standardised messaging which will be tailored to meet our organisation's needs (such as staff vaccinations, the promotion of key services and responding to incidents such as a critical incident to avoid confusion in messaging).

A representative from the communications team will continue to attend the daily organisational operational call and weekly system communications hub to monitor and react to system pressures, refining our messaging and tactics when needed.

Our aim and objectives

Our plan outlines our commitment to ensuring people receive the right care in the right setting, with a focus on doing more to support people to avoid being admitted to hospital by receiving care in their community and remaining independent at home; and, if they are admitted to our hospitals, supported to get back home as quickly as possible, with personalised wraparound care that meets their needs. This ensures people receive the right care in the right place, while aiming to reduce inappropriate attendances and pressure.

We will promote services such as The Harbour and Jack Sears, our discharge lounge and community teams which are supporting people in our hospitals and to remain independent at home and create content which celebrates colleagues and teams which work in the background to ensure services run safely.

We will place a strong emphasis on preventing ill-health and encouraging winter wellness through the uptake of seasonal vaccinations amongst our staff to protect patients, colleagues and our services.

Potential Emerging Risk

The following emerging risks could affect delivery of the Winter Plan, patient care and service continuity. Scores use the Trust's 5×5 matrix, calculated as likelihood × impact. Initial and residual ratings are planning assessments and should be reviewed by the relevant risk owners through established Trust governance.

Risk	Potential impacts	Initial score	Key controls and mitigations	Residual score
1. Winter Plan mobilisation and delivery failure	Planned capacity and service improvements are not available when required; unmet demand; deterioration in flow, performance and patient experience; increased reliance on escalation measures.	**16**	Named leads and milestones; weekly readiness review through the Winter Planning Group; recruitment and procurement tracked to deadline; dependencies and slippage escalated early; fallback delivery options and business-continuity plans maintained.	**12**
2. Emergency Department demand exceeds forecast	Sustained crowding and corridor care; four-hour deterioration; ambulance handover delays;	**20**	Daily demand surveillance; enhanced senior front-door decision-making; SDEC, UTC, HOT clinic, frailty,	**15**

	extended waits; increased risk of clinical harm and poor patient experience.		UCR and Virtual Ward pathways; predefined OPEL and surge actions; escalation through Safety and Flow meetings and system coordination.	
3. Winter escalation expenditure exceeds the financial plan	Unplanned staffing, agency, outsourcing, transport, accommodation, equipment and escalation-capacity costs; adverse variance; reduced financial flexibility elsewhere.	**16**	Costed escalation options; delegated financial approval thresholds; weekly expenditure and benefit review; agency controls; procurement oversight; prioritisation of actions with the clearest safety and flow benefit; early executive escalation of forecast variance.	**12**
4. Non-elective admissions exceed predicted levels	Pressure on medical, paediatric, critical-care and specialist beds; reduced capacity to absorb surges; higher occupancy; outlying; cancellation of planned care; increased clinical risk.	**16**	Daily predictive modelling and actual-versus-plan review; admission-avoidance pathways; senior streaming; SDEC and frailty services; Virtual Wards; criteria-led discharge; bed and staffing escalation plans; early system escalation.	**12**
5. Urgent pressure disrupts planned and elective care	Cancellation or postponement of surgery, diagnostics and specialist treatment; deterioration in RTT and cancer standards; clinical progression; poorer experience; loss of elective recovery income.	**16**	Protected day-case and priority capacity; formal elective stand-down criteria; clinical prioritisation of cancer, oncology, haematology and time-critical pathways; daily review of cancellations and recovery plans; executive approval	**12**

			for material reductions.	
6. IPC incidents and seasonal outbreaks	Ward closures, cohorting and isolation reduce beds; higher respiratory and critical-care demand; staff illness; reduced community and care-home capacity; transmission and avoidable harm.	**20**	Seven-day IPC service; vaccination campaign; daily surveillance and side-room review in EPIC; outbreak meetings; rapid testing, cohorting and isolation; fit testing and PPE monitoring; 24/7 deep-cleaning arrangements; workforce and community contingency plans.	**12**
7. Adverse weather disrupts services	Reduced staff availability; delayed patient access, discharge and transport; supply-chain interruption; disruption to community care; increased falls and weather-related demand.	**12**	Annual Adverse Weather Plan; Met Office and UKHSA alerts; early staff and supplier communications; gritting and estates response; remote-working and rota contingencies where appropriate; 4×4 response memorandum; patient transport and community business-continuity arrangements.	**8**
8. System-wide partner pressure	Reduced primary, community, mental-health and social-care capacity; more patients present to or remain in Trust services; delayed transfers; higher NCTR, occupancy and escalation.	**12**	NHS Devon coordination calls; shared capacity and escalation information; mutual-aid routes; joint discharge and complex-case reviews; system demand and capacity monitoring; agreed referral and escalation standards across partners.	**6**

9. Sustained high NCTR and delayed discharge	Longer length of stay; reduced bed availability and flow; ambulance queues and ED crowding; deconditioning, infection and poorer patient experience; reduced elective resilience.	**16**	Daily NCTR validation and medically-optimised review; early pathway identification; Band 7 D2A triage; Discharge Hub oversight; Trusted Placement Advisor support; escalation of Pathway 2 and 3 authorisations; Home First, Virtual Ward and intermediate-care utilisation; Twice weekly length-of-stay reviews.	**8**
10. Redeployment into unfamiliar environments	Reduced productivity; competence and supervision gaps; staff anxiety and fatigue; increased incidents; deterioration in quality, continuity and patient safety.	**12**	Role- and competence-based redeployment; local induction and orientation; clear scope of practice; buddying and clinical supervision; daily staffing risk assessment; staff wellbeing support; incident monitoring and escalation where safe staffing cannot be maintained.	**6**
11. Organisational change during winter	Uncertainty and reduced focus; slower decisions; unclear accountabilities; disruption to established processes; reduced leadership capacity to deliver winter priorities.	**16**	Communication with workforce, timely decisions and process.	**12**
12. Workforce sickness and absence exceeds plan	Unsafe or fragile staffing; service reduction; increased temporary staffing and redeployment; fatigue and burnout;	**16**	Vaccination and wellbeing programmes; twice-daily staffing review; roster and leave management;	**12**

	delayed care, discharge and operational response.		realistic absence assumptions in business-continuity plans; bank-before-agency controls; minimum staffing thresholds; proactive Occupational Health and management support.	
13. Estates safety changes reduce the acute bed base	Temporary loss of beds from refurbishment, infrastructure failure or decant; wider winter bed gap; reduced surge capacity; crowding, outlying and disruption to clinical pathways.	**20**	Detailed works and decant plans; executive review of timing and sequencing; daily capacity monitoring; rapid contractor escalation; coordination with IPC, clinical teams and EPRR.	**15**
14. Adult Social Care duties transition to Torbay Council	Disruption to workforce and budgets, with unclear roles, accountabilities and authorisation routes, may delay decisions and placements, including locality-led Pathway 2/3 discharges, Scheme of Delegation approvals, new Adult Social Care caseload management and reviews of short-term services or block-funded beds. This could destabilise integrated acute, community and social-care discharge pathways, increase NCTR and length of stay, and add pressure across	**16**	Joint transition governance will maintain a single action and risk log through Hub and Length of Stay meetings, supported by agreed workforce and financial plans, a documented interim operating model, clear roles, decision rights, authorisation thresholds and escalation routes. Continuity and handover plans will include workload and caseload monitoring, staff access to required documentation and maps, timely ASC referrals with interim support arrangements, regular 1:2:1s and targeted communications.	**12**

	acute and community services.		Authorisations exceeding four hours, locality-led Pathway 2/3 placements, discharge performance, NCTR, length of stay, block-bed use and acute and community capacity will be actively monitored, with delays escalated promptly for executive or system resolution.	

Risk owners will review the ratings, controls, delivery evidence and emerging triggers through Care Group and corporate governance, the Winter Planning Group and the Executive Committee. Material deterioration, control failure or a residual score outside the Trust's agreed risk appetite will be escalated in line with the Trust Risk Management Framework.

Torbay and South Devon NHS Foundation Trust

Appendix 1 – Equality and Quality Impact Assessment tool

Equality and Quality Impact Assessment Tool

The Equality and Quality Impact Assessment (EQIA) tool reviews any changes to policy or services, and considers how the change will impact quality, safety and equality. Any impacts identified could be negative, positive, or neutral.

Project lead:	**Executive Lead:** *Sam Wadham-Sharpe - Chief Operating Officer* **Medical Lead:** *Mark Roberts – Deputy Medical Director* **Nursing and AHP Lead:** *Natalie Herring – Deputy Chief Nurse* **Operational Lead:** *Craig Owen - Head of Operations*		
Proposal name:	Winter Plan 2026/27		
Proposal overview:	The Winter Plan 2026/27 is a Trust-wide programme of operational, clinical and workforce measures for October 2026 to March 2027. It includes urgent and emergency care redesign, a co-located UTC, expanded SDEC and HOT clinics, frailty and virtual-ward pathways, community diagnostics and admission avoidance, discharge and Home First improvements, elective protection, vaccination, IPC, workforce resilience, estates changes, transport, escalation and communications. It aims to reduce corridor care, delayed handovers, avoidable admission and length of stay while preserving urgent, elective, maternity, paediatric, community and specialist care.		
Names of those who have completed or directly contributed to this EQIA:	Winter Planning Group including: clinical, nursing, AHP, operational, care group, IPC, workforce, estates, EPRR, communications and improvement leads.		
Sources of information used to complete this EQIA (eg activity data, public health data etc)	Winter 2025/26 operational learning and formal debrief; 2026/27 demand, respiratory, bed and discharge modelling; May 2026 ED, occupancy, discharge and corridor-care data; GIRFT missed-opportunity audit; Corridor Care Summit programme; workforce, IPC, patient-safety, complaints and experience intelligence; Operational Surge, Flow and Escalation Policy; Adverse Weather Plan; national winter expectations and Board Assurance Statements.		
Is this proposal likely to impact:	Other care groups or services within the Trust	YES	Please ensure ALL other areas affected are consulted in this EQIA- including ICB
	Other parts of the broader Devon system (eg SWAST, other Trusts, primary care etc)	YES	

PART 1: EQIA screening tool

Quality domains	Positive	Neutral	Negative	Brief notes
Patient safety eg impact on safety	X			Earlier senior review, admission-avoidance pathways, discharge improvement, corridor-care reduction, seven-day oversight and IPC support should reduce harm. Residual risks include crowding, delayed handover, escalation areas, deterioration, falls, deconditioning, infection and staffing gaps.
Clinical effectiveness eg deviation from clinical guidelines	X			SDEC, HOT clinics, frailty, virtual wards and community diagnostics should improve right-first-time care. Benefits depend on reliable diagnostics, senior decisions, clear eligibility, safe discharge and seven-day capacity.
Patient & carer experience eg impact on choice		X		Care closer to home and fewer delays should improve experience. Transfers, remote monitoring, outbreak restrictions and discharge pressure may affect dignity, choice, communication and carer workload.
Well- led eg impact on staff experience		X		Clear governance, escalation standards and visible leadership support delivery. Sustained pressure, redeployment, fatigue and reduced recovery time may adversely affect staff experience and psychological safety.
Sustainability eg impact on environment	X			Home-based care, virtual pathways and reduced avoidable conveyance may reduce travel and resource use; transport, estate moves, energy use, equipment and surge activity may create potential environmental pressures.
Equity eg changing access & inclusion	X			Targeted prevention and community pathways may improve inclusion, but rurality, deprivation, transport, digital

				access, communication needs and variable capacity may create barriers.
Equality: Protected characteristics	**Positive**	**Neutral**	**Negative**	**Brief notes**
Age	X			Respiratory demand disproportionately affects young children and older people; use age-appropriate triage, frailty and paediatric pathways, safeguarding and carer involvement.
Disability (inc learning disability & mental health)			X	Physical, sensory, learning disability, neurodiversity and mental-health needs may make crowded or unfamiliar settings, relocation, transport, remote monitoring and rapid discharge less accessible. Provide reasonable adjustments, accessible information, liaison and advocacy.
Gender reassignment		X		No planned differential impact, but privacy, dignity, records and communication must recognise gender identity. Use inclusive records and language, person-centred placement and documented adjustments.
Marriage or civil partnership		X		No direct differential impact is expected. Confirm the patient's nominated contact and apply consent, confidentiality and information governance requirements consistently.
Pregnancy & maternity	X			Respiratory illness, infection exposure, delayed access and staff redeployment may create additional risk; protected maternity and neonatal pathways and vaccination support benefit.
Race		X		Language, health literacy, trust and different access patterns may affect navigation, consent, vaccination and discharge. Use professional interpretation, translated information and targeted engagement.

Religion & belief		X		Diet, prayer, fasting, treatment preferences, visiting and end-of-life practices may be affected by operational or IPC restrictions. Discuss needs individually and use chaplaincy, dietary and privacy adjustments.
Sex		X		Privacy, dignity, ward placement, violence risk and caring responsibilities may create different experiences. Apply person-centred placement, safeguarding and domestic-abuse pathways.
Sexual orientation		X		Partners or chosen family may be overlooked in communication and discharge planning. Use inclusive language, record the person nominated by the patient, maintain confidentiality and challenge discrimination.
Other marginalised groups (eg most deprived, carers)	X			People in deprived, rural or coastal communities, unpaid carers, people experiencing homelessness or digital exclusion, service families, veterans, prisoners and remote workers may face transport, cost, continuity, housing or access barriers. Use non-digital routes, transport, safe-discharge checks, targeted outreach and carer support.
Date of sign off at care group governance meeting:	3rd September via Winter Planning group.			

If there is any chance of negative impact on any domain or group, a comprehensive EQIA is required- progress to Part 2

Part 2: Full EQIA assessment of impact

Domain of impact: (quality or equality domain identified in Part 1)	**Description of impact and evidence to demonstrate impact**	**Initial risk score**	**Mitigations being taken to reduce negative impact**	**Residual risk score**	**How will ongoing impact be monitored?**
Patient safety and patient/carer experience	Crowding, corridor care or delayed ambulance handover may cause avoidable harm or loss of dignity. Earlier senior review, alternatives to admission and discharge improvement provide benefit, but sustained crowding remains a risk.	12 I:3 L:4	Daily Safety and Flow oversight; eliminate routine corridor care; escalation standards; senior clinical review; safe staffing and equipment checks; incident and harm review.	6 I:3 L:2	Corridor-care episodes; 12-hour waits; ambulance handover delays; deterioration, falls, pressure damage, incidents, complaints and harm reviews. Reduction in escalation beds.
Clinical effectiveness and equity	UTC, SDEC, HOT clinics, frailty, virtual wards and Home First may improve timely care, but eligibility, communication, transport, digital exclusion and inconsistent seven-day capacity could create unequal access.	10 I:2 L:5	Clear criteria; consent and capacity checks; interpretation and accessible information; reasonable adjustments; non-digital access; transport and safe-discharge planning; audit exceptions.	5 I:1 L:5	Admission conversion; utilisation; 72-hour reattendance; readmission; length of stay; access and outcomes by protected characteristic, deprivation and locality; complaints.
Well-led, staff and patient safety	Sustained pressure, redeployment, additional hours and workforce gaps may increase fatigue, distress, burnout and clinical risk.	12 I:3 L:4	Twice-daily safe-staffing review; competence-based deployment and induction; supervision; protected breaks and fatigue controls; wellbeing support; escalation where standards cannot be met.	9 I:3 L:3	Fill rates; sickness; turnover; complaints; temporary staffing; missed breaks; staff incidents; wellbeing referrals; patient-safety indicators and pulse-survey themes.

Sustainability, access and system impact	Estates works, adverse weather, transport constraints, outbreaks or discharge-system capacity may reduce beds, disrupt access and shift demand to community services and unpaid carers.	16 I:4 L:4	Accessibility, clinical, fire and safety review before moves; wayfinding and privacy; transport and weather escalation; joint demand-capacity review; shared risk logs and mutual-aid routes.	12 I:4 L:3	Bed closures and occupancy; delayed discharge and NCTR; UCR response; transport delay; community capacity; access complaints; system escalation and mutual-aid requests.

		LIKELIHOOD				
		1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
IMPACT	**1 Low**	**1**	**2**	**3**	**4**	**5**
	2 Slight	**2**	**4**	**6**	**8**	**10**
	3 Moderate	**3**	**6**	**9**	**12**	**15**
	4 Severe	**4**	**8**	**12**	**16**	**20**
	5 Catastrophic	**5**	**10**	**15**	**20**	**25**

Appendix 2 – Winter plan – New Initiatives on a page



BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust

October 2026

Our Estate
Our People
Our Digital

Executive Summary

Torbay and South Devon NHS Foundation Trust

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	Moderate Assurance	Limited Assurance	Inadequate Assurance

Workstream Progress Summary

Significant
Moderate
Limited
Inadequate

Torbay and South Devon NHS Foundation Trust

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

Key Updates in Month:

- OPFBC Oversight approved the closure of the **Frailty Expansion** workstream at the INT Programme Group. Remaining deliverables will transfer to the UEC Recovery Programme through the Eliminating Corridor Care workstream. A formal handover of associated RAID, KPI and performance information will ensure continuity of delivery and oversight. A closure report is included within this month's papers for OPFBC Oversight approval.

- OPFBC Oversight approval to close the **Virtual Wards** workstream was granted last month. Due to the OPFBC Oversight meeting being stood down, approval was provided outside the formal meeting cycle. Remaining deliverables will transfer to the Right Pathway workstream and Eliminating Corridor Care Improvement Programme in line with the closure report.

- Capacity constraints continue to limit the pace and scope of the **Clinical Services Review**. Delivery activity is currently prioritised on Trauma & Orthopaedics, identified as the highest-priority service area, with executive oversight required to support delivery of the improvement plan, benefits realisation and risk management. Emergency Medicine is the next priority area, while Women's and Children's Services continue to progress through a locally developed improvement plan supported by existing governance arrangements.

- **Productivity** activity has been refocused on four priority areas: theatres, outpatients, medical staffing and diagnostics. Improvement workbooks have been issued to support opportunity identification, improvement planning and benefits realisation, with the Outpatients and Medical Staffing workstreams now completing detailed planning and transitioning into delivery. Care groups are reporting increased clinical engagement and emerging benefits, supported by improvements in outpatient productivity, clinic capacity and medical workforce planning.

- The **One Devon Shared Services Finance** workstream continues to experience delays, with the SBS go-live date further deferred. A revised implementation timetable is expected to be confirmed by mid-October, enabling programme re-planning, dependency management and alignment of downstream activity.

The Transformation Programmes Impact to CIP (M6)

Torbay and South Devon NHS Foundation Trust

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	£ -	£ -	£ 626,530	£ -	£ -	£ 626,530	-£ 594,470
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 176,242	£ 50,000	£ 126,242	£ -	-£ 1,032,238
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 189,251	£ -	£ -	£ -	£ -	£ -	£ -	-£ 189,251
1.5 Adult Social Care Transition	£ 11,390,000	£ 7,855,417	£ 1,955,979	£ 2,547,055	£ 6,687,128	£ 500,000	£ 2,124,238	£ 4,062,890	-£ 1,168,289
2.2 Improving Productivity	£ 1,150,000	£ 650,000	£ 375,000	£ 750,000	£ 750,000	£ -	£ -	£ 750,000	£ 100,000
4.2 Epic implmentation & benefits including MyCare	£ 5,656,312	£ 5,313,823	£ 1,265,277	£ 2,057,661	£ 4,253,096	£ 369,164	£ 1,784,917	£ 2,099,015	-£ 1,060,727
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ 125,015	£ 896,546	£ 1,110,233	£ -	£ 213,687	£ 896,546	-£ 1,786,367
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ 8,830	£ 69,628	£ 2,078,628	£ 225,000	£ 1,400,000	£ 453,628	£ 504,628
Our Plan for Better Care Total	**£ 25,499,907**	**£ 20,908,571**	**£ 3,730,101**	**£ 6,320,890**	**£ 15,681,857**	**£ 1,144,164**	**£ 5,649,084**	**£ 8,888,609**	**-£ 5,226,713**
Other Non Pay - Procurement	£ 1,915,000	£ 1,717,511	£ 532,025	£ 1,134,658	£ 1,984,362	£ 257,000	£ -	£ 1,727,362	£ 266,851
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,461,316	£ 600,000	£ 600,000	£ 2,459,853	£ -	£ -	£ 2,459,853	-£ 1,463
Other Care Group Schemes	£ 24,404,877	£ 29,332,366	£ 11,620,889	£ 17,101,309	£ 34,293,691	£ 2,072,000	£ 6,497,397	£ 25,724,294	£ 4,961,325
Total	**£ 54,419,784**	**£ 54,419,764**	**£ 16,483,015**	**£ 25,156,857**	**£ 54,419,763**	**£ 3,473,164**	**£ 12,146,481**	**£ 38,800,118**	**-£ 0**

The Trust's 2026/27 CIP target is **£54.4m**, of which Our Plan for Better Care (OPFBC) accounts for **£20.9m** (38%).

OPFBC has delivered **£3.7m** year to date, with **£6.3m** transacted for the full year. Its **£15.7m** forecast leaves a **£5.2m** shortfall, forecast which has been offset by additional Care Group schemes developed in year.

Schemes outside OPFBC, including Procurement, Medicines Optimisation and local Care Group schemes, have forecast outturn of **£38.7m**, bringing the total Trust forecast to **£54.4m**, in line with target.

Trustwide delivery totals **£16.5m** year to date, with **£25.2m** in full-year transacted savings. Achieving target depends on a further **£29.2m** of forecast savings, including **£3.4m** assessed as high risk and **£12.1m** as medium risk.

Reviews of medium- and high-risk schemes are testing delivery assumptions and strengthening mitigations to secure the remaining savings.

In-year Trustwide recurrent savings are forecast at **£36m**, **£7.4m** below the **£43.4m** recurrent target however additional non-recurrent savings are forecast to offset this gap, maintaining the overall forecast at target.

The full-year effect of recurrent savings is forecast at **£43.7m**, ahead of plan, indicating a stronger recurrent exit run rate than the in-year position. Scheme implementation timing remains key to realising these benefits.

RAID Management

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

RAID items continue to be actively managed through the established governance cycle. The reduction reported this month reflects the approved closure of the Virtual Wards and Pathway Review and Redesign workstreams, alongside the proposed closure of the Frailty Expansion workstream. Remaining RAID items are being formally transferred to ensure continued oversight and management. The Acute Bed-Based Care workstream remains on hold.

RISKS

- At the start of the reporting period, there were **76 open** risks. During the period, **1 new** risk was identified and **13 risks were closed**, 11 associated with workstreams that have now closed and 2 Epic implementation where the risks are no longer deemed a risk to delivery. 2 risks have been identified for escalation.

ASSUMPTIONS

- At the start of the reporting period, there were **64 open** assumptions. No new assumptions were identified and **15 assumptions were closed**, including 13 associated with workstream closures and 2 within Digital First where the related activity has now been completed. No assumptions require escalation.

ISSUES

- At the start of the reporting period, there were **17 open** issues. No new issues were recorded and **1 issue was closed**. 4 issues have been identified for escalation.

DEPENDENCIES

- At the start of the reporting period, there were **93 open** dependencies. No new dependencies were recorded and **18 dependencies were closed**, including 17 associated with workstream closures and 1 within the Innovation and Evaluation Hub where the dependency is no longer applicable. No dependencies require escalation.

Domain / Workstream	No. of Risks	No. of Assumptions	No. of Issues	No. of Dependencies
1.0 Living Well in our Neighbourhoods	**18**	**12**	**5**	**22**
1.1 Frailty Expansion and Community Bed-Base Care Review	0	0	0	0
1.2 Acute Bed-Base Care Review	4	1	0	6
1.3 Virtual Ward & Hospital at Home Service	0	0	0	0
1.4 Neighbourhood Teams Infrastructure & Support	6	3	3	6
1.5 Adult Social Care Transition	6	4	1	6
1.6 Innovation & Evaluation Hub	2	4	1	4
2.0 Reimagining Acute & Specialist Care	**26**	**20**	**9**	**35**
2.1 Clinical Services Review	11	5	1	17
2.2 Improving Productivity	2	2	1	5
2.3 Pathology	13	13	7	13
3.0 Joined-up Care, Every Step of the Way	**0**	**0**	**0**	**0**
3.1 Pathway Review and Redesign	0	0	0	0
4.0 Smart use of technology for better care	**8**	**9**	**0**	**10**
4.1 Digital First	2	5	0	6
4.2 Epic Implementation & Benefits, including MY CARE	6	4	0	4
5.0 Caring, skilled people ready for tomorrow	**5**	**4**	**1**	**4**
5.1 Workforce Transformation	4	2	1	4
5.2 Culture Transformation	1	2	0	0
6.0 Strategic Enablers	**7**	**4**	**1**	**4**
6.1 One Devon Shared Services – Finance	7	4	1	4
Total	**64**	**49**	**16**	**75**

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

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RISK – In October, 2 risks have been identified by SROs for escalation, providing assurance that risks are being effectively managed and mitigated within individual workstreams.

Workstream	Trigger (Why something may happen)	Risk (What could happen)	Impact (Likely consequence if left untreated)	INITIAL Risk Score	Treatment/Mitigation Actions	Action Owner	Action Status	CURRENT Risk Score	TARGET Risk Score	Trend
1.5 Adult Social Care	Insufficient staffing levels (clinical, operational, or project resources) allocated to the ASC transition programme.	Inadequate resources are available to plan, manage, and execute the ASC transition effectively.	Delays to transition timelines and key milestones. Reduced quality of implementation, leading to operational inefficiencies.	16	1) Undertake detailed workforce planning aligned to transition milestones.	Lisa Heard	Complete	16	8	⬌
					2) Ringfence time.	Lisa Heard	Complete			
					3) Monitor where workstreams are falling behind and escalate.	Lisa Heard	In Progress			
					4) Procure external SMEs.	Lisa Heard	Complete			
					5) Additional staffing mitigation actions, including agency worker arrangements	Nicola McCminn	In Progress			
5.1 Workforce Plan & transformation	Delays or restrictions arising from the revised vacancy control process.	Essential workforce vacancies are not recruited to within required timescales.	Reduced organisational capacity impacts service delivery, operational performance, workforce sustainability, delivery of transformation priorities and achievement of financial objectives.	12	1) Ongoing monitoring, governance and workforce planning will be required to balance affordability, patient care and organisational resilience.	Kelly Ebdon-Marks	In Progress	9	6	★

ASSUMPTIONS – In October, 0 no assumptions require escalation in this reporting period.

DEPENDENCIES - In October, 0 no assumptions require escalation in this reporting period.

RAID Escalations

ISSUES – In October, 4 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
1.5 Adult Social Care– I-026	Clarity required on the completeness and outcomes of ASC reviews.	Critical	Available information does not provide sufficient assurance to confirm full cost. Delivery of 2026/27 CIP savings does not achieve CIP Target.	1. Obtain the requested trajectory for remaining Adult Social Care reviews and assess the financial implications of reviews that will not be completed before transfer. 2. Review cases identified as containing delegated health tasks to establish the genuine health component and associated funding responsibility. 3. Use contract information and agreed assumptions to support allocation of health and social care expenditure and completion of the financial baseline.
2.1 Clinical Services Review I-017	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. Refocus Clinical Services Review workstream. 2. Capacity concerns still to be addressed through restructure.
2.2 Productivity I-019	Insufficient dedicated resource, analytical capacity, or technical expertise cause productivity initiatives to be poorly designed, slow to be progressed, or are not robustly evidenced.	Critical	Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements.	1. Refocus and reduction of cross cutting themes. 2. Capacity concerns still to be addressed through restructure.
6.1 One Devon Shared Services – Finance – I-027	System not ready resulting in delay of go live date from 1st October.	Critical	SBS does not go live 1st October. ONE Devon Finance Hub would be delayed.	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.

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

- The principal risks to programme delivery relate to **competing organisational priorities, workforce capacity constraints**, and **dependencies on external programmes and partners**. Significant operational, clinical and transformation demands, including organisational restructuring, winter pressures and tower block developments, may reduce the capacity available to support delivery and impact the pace at which planned outcomes are achieved.

- Workforce challenges, including voluntary redundancies, organisational restructuring and recruitment controls, may result in the loss of experienced staff and specialist expertise, creating potential gaps in programme knowledge and delivery capability. In addition, the programme remains dependent on a number of interrelated initiatives, funding decisions and partner organisations, meaning delays or changes elsewhere could have a consequential impact on delivery timescales and benefits realisation.

- As the programme enters Q3, a more detailed review of programme-level risks, interdependencies and mitigations will be undertaken to strengthen risk management arrangements and ensure emerging risks are appropriately reflected within the programme governance framework.

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Appendices

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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

- ✓ The business case for the seven-day Frailty SDEC service was completed and approved through TIG, Triple Lock and Private Trust Board on 02 July 2026.
- ✓ The mobile X-ray service completed end-to-end testing and commenced service. The contract was awarded on 24 July 2026 following completion of governance and legal approvals.
- ✓ Two deliverables were formally closed by OPFBC Oversight on 17 June 2026 because they were no longer aligned to the programme plan: the Newton Abbot care co-ordination hub and community ward change of use.
- ✓ Recruitment and formal consultation for the seven-day Harbour service were progressing, with consultation commencing on 28 September 2026 and interviews commencing on 09 October 2026.
- ✓ Redirection tests of change from acute to community settings commenced, alongside right-care meetings and Eliminating Corridor Care project activity. • Care-home Emergency Department attendances reduced from a baseline average of 4 per day to the target of 2 per day.
- ✓ The Newton Abbot Hospital transfer rate to the acute site was 34% against a target of below 30%, so this outcome requires continued monitoring.
- ✓ CGA performance and the measure relating to patients with three or more acute admissions within 90 days of end of life remained to be confirmed, including completion of Epic data correlation.

Next Steps

- OPFBC Oversight approved closure of the workstream on 21 October 2026, with the remaining deliverables transferring to workstreams within the UEC Recovery Programme.

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
Reduced attendances from care homes in ED (av/daily attendance)	4	2	N/A	N/A
80% of patients have a CGA (*awaiting Epic data correlation)	0	80%	N/A	N/A
Transfer rate from NAH into Acute Site between 10-30%	0%	<30%	N/A	N/A
Reduction number of patients with 3+ acute admissions ≤90 days EOL	44	TBC	N/A	N/A

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*

Assurance	Rating
Executive Sponsor Rating	**Workstream Closed**

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 *(Risks, Issues) (Assumptions, Dependencies)*

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

- ✓ **Progress achieved:** The workstream reviewed existing GIRFT clinical pathways and aligned pathway activity with operational, neighbourhood and urgent and emergency care transformation priorities. Sub-specialty discussions continued to provide clinical input into the future operating model, and key activities were aligned with the Eliminating Corridor Care programme to reduce duplication and maximise the value of improvement activity.
- ✓ **Benefits realised to date:** The principal benefit at closure is stronger strategic alignment and a clearer route for continued delivery. Clinical pathway review has established a foundation for standardised step-up and step-down pathways, while integration with the wider transformation programme provides a route to coordinate workforce, data, digital, community response and quality requirements. Full quantitative benefits have not yet been evidenced because KPI baselines, targets and performance reporting remain under development.
- Recommendation: Approve closure of the 1.3 Virtual Ward & Hospital at Home Service as a standalone workstream.

Next Steps

- OPFBC Oversight approved closure of the workstream on 21 October 2026, with the remaining deliverables transferring to the Right Pathway and Eliminating Corridor Care Improvement Programme.

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				

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*

Assurance	Rating
Executive Sponsor Rating	Workstream closed

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

Torbay and South Devon NHS Foundation Trust

Delivered

The SRO is not providing a substantive update this month while the workstream is being refocused to clarify neighbourhood ownership, priorities and delivery arrangements. This will inform refreshed deliverables, with delivery remaining the responsibility of neighbourhood and Integrated Neighbourhood Team (INT) groups, supported by clear governance and reporting arrangements.

Please note: all other data presented within this report reflects previously reported activity and has not been updated this month.

Next Steps

Meetings:

- Devon Frailty Neighbourhood Working Summit, Tuesday 13th October 10am - 4pm.
- A workstream deep dive will be conducted at the INT meeting on 3 November 2026 to confirm future scope, priorities and deliverables.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Flat growth rate across UEC demand (current forecast 6.5%)	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 *(Risks, Issues) (Assumptions, Dependencies)*
No RAID for escalation in this reporting period.		

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
	Rationalisation of Estate- Teignmouth hospital	321,000	189,251	0	0	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

At Operational level, the project is progressing as planned with workstreams working through their deliverables and actions. At strategic level issues remain in relation to client validations, Hollacombe/Carers service management and finalising measures queries.

- ✓ Programme governance arrangements have progressed with regular project manager meetings, providing enhanced oversight, coordination, and accountability across workstreams. KPI targets have also been established to support performance monitoring and delivery assurance against programme objectives.
- ✓ Human Resources consultation commenced on 08/09/2026. Final queries on team splits resolved except Hollacombe/Carers. Measures letter responded to and reply expected 28/09/2026. Pension data submitted & update from Torbay Council expected end September. Briefing for managers in relation to consultation 1:1s shared.
- ✓ Operations – Health Model in draft and being finalised. Ongoing correspondence with Torbay Council in relation validating clients' arrangements.
- ✓ Finance continue work on residual costs, client debt and the financial baseline as scope is clarified. Health model costings received. Continuing Healthcare (CHC) payments confirmed as to be managed via an SLA with Torbay Council.
- ✓ Estates and IT progressing access and system application requirements post transfer. Frequently asked Questions (FAQs) developed to include plan of data transfer relating to Teams channels, emails, OneDrive.
- ✓ Legal and Governance drafting the Transfer Agreement, finalising the legal response regarding Hollacombe and continue data transfer arrangements.
- ✓ Contracts and Commissioning continue to validate contracts and add additional detail to log.
- ✓ Data and Analytics reporting following LiquidLogic launch resuming. Modelling to support new health model underway.
- ✓ FAQs updated and regular comms sent to impacted staff groups. Drop-in sessions progressing.

Next Steps

- Programme governance – Torbay Council & TSD programme teams to draft joint brief for Transition Board.
- Human Resources – complete 1:1's. Clarify pension arrangements; salary sacrifice and provide DBS data. Continue weekly managers drop-in sessions.
- Operations – Finalise Health Model, cost & put through governance sign off. Agree client validation process and timeframes.
- Finance continue work on residual costs, client debt and the financial baseline as scope is clarified. Health model costings & Business Case finalisation.
- Estates and IT complete access and application requirements post transfer.
- Legal and Governance drafting the Transfer Agreement, finalise the legal response regarding Hollacombe and continue data transfer arrangements.
- Contracts and Commissioning will be continuing to validate contracts as numbers fluctuate. Best Interest Assessor contracts added to scope.
- Data and Analytics – complete modelling to support Ops team & carry out training required on new systems.
- The Stage 2 Equality Impact Assessment to be drafted.

Key Performance Indicator	Baseline	Target	Current Position	Trend
See slides 16 & 17 for detail.				

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*
Risk	16	**R-057 -** Insufficient staffing levels (clinical, operational, or project resources) allocated to the ASC transition programme.
Issue	Critical	I-026 Clarity required on the completeness and outcomes of ASC reviews.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's (FYE)	Forecast Outturn £000's	26/27 Original WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
7 schemes	6,200,000	7,855,417	2,547,055	6,687,129	0.00	5.00	0.00	5.00	
1 scheme	5,190,000	0	0	0	0.00	0.00	0.00	0.00	

1.5 Adult Social Care – Proposed KPIs

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Workstream	KPI	Target	Actual	Trend	Numerator and start date if zero	Value	Denominator	Value
Human Resources & Staffing	% of colleagues assessed for scope of transfer	N/A	48%	↘	No of colleagues assessed by TSD as within scope of transfer	303	No initial staff identified by TSD	629
	% of colleagues agreed with Council for transfer	100%	76%	↗	No of colleagues agreed with council for transfer	230	No of colleagues assessed as in scope of transfer	303
	% Achievement of key TUPE milestones due completed on time	100%	100%	→	No of key milestones due completed on time	02/10	No of key milestones due	02/10
Finance	Residual Cost Value remaining with TSD post transfer (Staffing, Estates and reduced flow capability)	N/A	Unknown (TBC post TUPE outcome)	→				
	% Debt Cases with agreed ownership	100%	0%	→	Number Debt Cases with agreed ownership *(under negotiation with TC)*	0	Number Debt Cases	1,380
	% Debt with agreed ownership (£)	100%	17%	↗	£m's Debt with agreed ownership	2.7	£m's Debt	15.6
Operations	% Pathways where future state agreed between TSD and TC	100%	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 since 1/4/26	70%	27%	↗	Number of ASC Reviews reviewed since 1/4/26 (Reviewable Packages of Care)	753	Number of ASC Reviews to be completed (Reviewable Packages of Care)	2,770
	% ASC Reviews in date	70%	53%	↗	Number of ASC Reviews in date	1240	Number of ASC Reviews to be completed (Reviewable Packages of Care)	2,770
Estates	% of buildings accommodating ASC staff that are leased/freehold	100%	93%	↗	No of properties with tenancy details	13	No Buildings accommodating ASC staff	14
	% cost of occupation reviewed	100%	100%	↗	No occupation cost reviewed	14	No Buildings accommodating ASC staff	14
Legal & Governance	% queries requiring internal legal services advice closed	100%	100%	↗	No queries requiring internal legal services advice closed	2	No queries requiring internal legal services advice raised	2
	% Court of Protection Orders reviewed	95-100% Not due to March 27	96%	↗	COP Applications made/acknowledged by the Court	223	Court Orders that will need transferring to Torbay Council	223 (+33 pending)

1.5 Adult Social Care – Proposed KPIs

Workstream	KPI	Target	Actual	Trend	Numerator and start date if zero	Value	Denominator	Value
Contracts & Commissioning	% ASC Contracts reviewed	100%	100%	→	No ASC Contracts reviewed	448	No ASC Contracts	448
	% ASC Contracts with plan agreed	100%	98%	↘	No ASC Contracts with plans	440	No ASC Contracts	448
	% ASC Providers set up TC Digital Platform Account	100%	31%	→	No ASC Contracts with Digital Platform set up	135	No **applicable** ASC Contracts	440
	% Health Contracts reviewed	100%	100%	→	No Health Contracts reviewed	34	No Health contracts	34
	% Health Contracts with plan agreed	100%	100%	→	No Health Contracts with plans	34	No Health contracts	34
Data & Analytics	% Statutory Returns and Reports catalogued	100%	100%	→	No Statutory Returns and Reports catalogued	75	No Statutory Returns and Reports	75
	% Staff completed PBI training (booked November)	100%	0%	→	No Staff completed PBI training *(to commence in November)*	0	No Staff to receive PBI training	3
	% Priority reports transferred from Tableau to PBI ahead of 01/04/2027	100%	0%	→	No priority reports transferred from Tableau to PBI ahead of 01/04/2027 (dependent on training)	0	No priority reports to be transferred from Tableau to PBI ahead of 01/04/2027	7
IT & Infrastructure	% Applications assessed for transition impact	100%	0%	→	No applications/systems assessed *(commenced 01/08 and in progress)*	0	No applications/systems in scope	11
	% Staff with agreed application/system access requirements	100%	0%	→	No staff with agreed application and system access requirements *(commenced 01/08 and in progress)*	0	No of colleagues agreed with council for transfer	230
	% Data migration and archive requirements defined	100%	100%	→	No data migration/archive requirements defined	4	No of systems data migration/archive requirements identified	4
	% Key IT transition decisions progressed through Goverance	100%	9%	↗	No key IT transition decisions progressed through Governance	1	No key IT transition decisions progressed through Governance identified	11
Communications & Engagement	% Engagement Events completed	80%	85%	↗	No Engagement Events completed	17	No Engagement Events	20
	No of Staff emails released	N/A	9	↗				
	% FAQs with responses	100%	98%	↗	No FAQs with responses	100	No FAQs	102
	No of ASC Transfer views on ICON	N/A	719	↗				

1.6 Innovation & Evaluation Hub

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Implementation of the ISG Gateway Process will progress following formal approval of the framework, which is now scheduled for the ISG meeting on 8 October 2026 following the cancellation of the September meeting.
- ✓ Dashboard development continues in partnership with the IT team, with a review meeting planned for the week commencing 5 October 2026. Delivery remains on track for completion by the end of October 2026.
- ✓ Legal agreements supporting the HIN South West Academic Partnership are being finalised by TSDFT and HIN South West legal teams,
- ✓ Legal agreements supporting the NHSE Partnership are being finalised by TSDFT and NHSE legal teams. Board consideration of the NHS Region Partnership Agreement remains a key milestone in October following deferral from the September Board agenda
- ✓ The Chief Planning and Strategy Officer (CPSO) is currently reviewing the proposed organisational restructure, including the implementation lead role, following feedback received from the People Directorate and Executive team.
- ✓ No material progress on the Rapid Bid Funding programme has been reported during the period. Positively, funding of £18k has now been secured, providing the necessary foundation to support initiation of the programme.

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 now consists of 40 projects and have been formally approved at triage stage in August ISG. With the additional projects, 14 of 40 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.	Joint Paper between Chief Operating Officer and Workstream Lead has been prepared and is currently with CPSO to review and sign-off.	↑
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.	⟷

Next Steps

- Evaluation Framework to be presented at ISG.
- Expect the legal matters around NHSE Partnership Agreement to be sign-off and completed.
- Continue legal article work on HIN Partnership to a position of sign-off
- Obtain clarity around team restructure and undertake informal restructure meeting.
- Start development work for Rapid Bid Funding initiative

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

Assurance	Rating
Executive Sponsor Rating	Moderate

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										

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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

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NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The Clinical Service Review workstream should continue to provide executive oversight of key service improvement and sustainability priorities, including Trauma & Orthopaedics (T&O), Emergency Medicine and Women's & Children's Services. The workstream provides an established governance framework to oversee improvement plans, manage performance and cost pressures, and support future specialty reviews aligned to the Trust's wider Service Sustainability agenda.
- ✓ The OPFBC Oversight Group has agreed to refocus the workstream towards services facing the greatest operational, productivity and financial challenges to maximise organisational impact. Progress has been constrained by capacity limitations, with T&O remaining the primary area of focus. A comprehensive evidence base and diagnostic review have now been completed, resulting in an agreed clinically-led transformation programme focused on pathway redesign, workforce optimisation, productivity improvement and long-term service sustainability.
- ✓ Trauma & Orthopaedics (T&O), identified as the highest-priority service area through operational, financial and productivity analysis, has completed a comprehensive diagnostic review resulting in an agreed clinically-led transformation programme focused on pathway redesign, workforce optimisation, theatre efficiency, digital utilisation and service sustainability. As a priority service area, the T&O improvement programme is now underway and requires continued executive oversight through this governance structure to support delivery, benefits realisation and risk management. Governance arrangements, delivery structures and phased implementation plans are now in place, with delivery commencing under executive sponsorship. The programme is expected to deliver improvements in productivity, patient flow, waiting times and financial performance, with anticipated benefits significantly exceeding the investment required.
- ✓ Further specialty sustainability reviews are being progressed, with Emergency Medicine identified as the next priority area. While the GIRFT review and associated recommendations will form a key component of the improvement programme, wider operational, workforce, productivity and financial challenges remain that require further investigation, including areas outside the scope of GIRFT, such as nursing workforce costs. Operational, financial and productivity analysis is underway to identify improvement opportunities and develop evidence-based recommendations aligned to service sustainability, GIRFT principles and financial recovery objectives.
- ✓ Women's & Children's Services remain an important area of focus. Whilst system-wide discussions continue, the Care Group has developed a local improvement plan in response to the Clinical Services Review, providing an opportunity to drive improvement activity through existing governance and executive oversight.
- ✓ The workstream also provides an established governance framework to oversee future specialty sustainability reviews, supporting the Trust's focus on operational, financial and clinical sustainability while maintaining executive oversight.

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)*
Issue	Critical	I017 - 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

Next Steps

- Mobilise delivery of the Trauma & Orthopaedics Transformation Programme through established governance arrangements, executive oversight and clinically-led improvement structures.
- Commence Phase 1 improvement initiatives focused on trauma pathways, admissions and scheduling processes, and fracture clinic optimisation
- Continue specialty sustainability reviews, including Emergency Medicine, to identify cost drivers, benchmarking variation and productivity opportunities.
- Engage clinical and operational leaders to validate findings and agree evidence-based improvement priorities aligned to GIRFT recommendations and financial sustainability objectives.

Assurance	Rating
Executive Sponsor Rating	Limited

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

2.2 Productivity Including Best Practice

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Care Group reviews have embedded the reset within specialty action plans. Care Groups report stronger clinical engagement and clinic template redesign, with associated activity and financial benefits forecast at specialty level.
- ✓ Sub-groups are developing detailed deliverables and milestones to support workstream objectives, with Outpatients and Medical Staffing plans now complete.
- ✓ Outpatients: Bookwise phase 1 is complete with all 125 licences in use. Tableau reporting has expanded, with clinic-level productivity data due w/c 12 October. September DNA performance is 4.9%, below the 5% target.
- ✓ Care Groups are reviewing clinic variation and increasing new-patient capacity, including replacing follow-ups where appropriate. Cardiology has agreed revised templates.
- ✓ Medical staffing: job planning has restarted. Committee terms of reference have approval in principle, the contracted 12+ PA cohort is confirmed/ready for further review, and initial DCC/SPA analysis is complete.
- ✓ On-call template corrections and retirement-return record retrieval are under way. FDG highlighted the need to strengthen leave planning, delivery of contracted activity and approval controls for additional medical hours. Wider review remains constrained by capacity.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Extensive number of KPI's required for this workstream. Please refer to slides 22-23 for the latest KPI performance update and progress against key measures.				

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*
Issue	Concerning	I-019 -Insufficient dedicated resource, analytical capacity, or technical expertise cause productivity initiatives to be poorly designed, slow to be progressed, or are not robustly evidenced Action Plan: Mitigation to recover this are being managed by SRO and Workstream Lead.

Next Steps

- Progress specialty plans and commence tracking and reporting of activity/financial benefits through QPAGs and FDG.
- Finalise Theatres & Diagnostics detailed deliverable & milestone plans
- Roll out clinic-level Tableau reporting and resolve M6 activity/coding discrepancies with Finance.
- Progress Bookwise business cases, Epic PIFU changes and SPoA planning, subject to A&G readiness.
- Draft job-planning paper by 15 October, agree reviews by 22 October and confirm lead funding by 31 October.
- Progress 12+ PA/DCC/SPA reviews, on-call mapping and retirement-return review against November milestones.
- Review leave and additional-hours approval controls. Rebook the national job-planning deep dive.
- Confirm outstanding SLR, Productivity Analyser and CSU actions from September.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-022	Same Day Cancellations in Theatres	150,000	150,000	0	0	0.00	0.00	0.00	0.00	
27-081	Finance – NHSE Variable Contract	1,000,000	500,000	750,000	750.000	0.00	0.00	0.00	0.00	

2.2 Productivity Including Best Practice – KPIs

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

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 souring 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	4.8% (Sept 2026) Source: ICB	
• First to follow up ratios	TBC from GIRFT work	Target TBC by SRO Peer median = 2.0 Provider median =2.0	1:2.8 (Sept 2026) Source: ICB However: Tableau is showing 1:3.3	
• 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% (No data this month so still reflecting March 2025) Source: MHS – no new data	
• % activity undertaken as virtual	TBC from GIRFT work	ICB Target = 25% Peer median = 20.9% Provider median =18.8%	15% (Sept 2026) 14% (July 2026) Source: Tableau	
• % 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 . 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%	17.3%(Sept 2026) 14.8% (July 2026) Source: ICB	
THEATRES (Sept KPI's were unavailable at time of reporting)				
• % 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				

2.3 Pathology

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ TSD Acute Services Laboratory (ASL) specification and Pathology workforce model agreed. TSD Equality and Quality Impact Assessment also approved.
- ✓ First draft of the Joint Full Business Case submitted to the SROs and subsequently considered by the Joint Partnership Board.
- ✓ The Joint Partnership Board has identified further work to strengthen the Full Business Case, including refinement of the financial position, costing methodology, clinical operating model, logistics arrangements, and commercial income opportunities, prior to consideration of the next stage of approval.
- ✓ Executive-identified financial elements are being revisited with Finance support to strengthen affordability and financial assurance.
- ✓ Full Business Case, Target Operating Model and TSD ASL specification submitted to the Peninsula Pathology Network for external scrutiny and impartial clinical appraisal.
- ✓ RIBA Stage 3 floor plans substantially completed by 30th September, subject to outstanding ventilation and fire Authorising Engineer approvals.

Next Steps

- Continue the executive-identified financial review with Finance support, including affordability, costing assumptions, commercial income, supplier benefits and VAT.
- Complete further clinical and logistics modelling arising from the Joint Partnership Board review.
- Engage key clinical stakeholders, including Microbiology, Intensive Care, Infection Prevention, and other clinical users.
- Complete the Peninsula Pathology Network review of Full Business Case, Target Operating Model and TSD ASL specification.
- Secure outstanding ventilation and fire Authorising Engineer approvals to complete the RIBA Stage 3 milestone.
- Confirm progress on the retained Histopathology accommodation works following the cytology relocation.
- Hold executive review to determine Board progression of the Full Business Case. Reflect the financial, clinical, logistics and external assurance work in the next iteration of the Joint Full Business Case.

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 RIBA 3 completion has moved to the end of September. Floor plans are complete and the remaining mechanical and electrical design and Authorising Engineer assurance are not expected to affect the wider programme.	

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*

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										

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4.0 Smart use of technology for better care
Senior Responsible Owner – Sam Wadham-Sharpe, 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

Progress has been made across several digital transformation initiatives:

- ✓ **Appointment Intelligence Tool**: Engagement with Epic has commenced to assess the Appointment Intelligence Tool's functionality and integration requirements, with a further workshop scheduled on 07/10/2026 to confirm implementation approach, delivery requirements, and revised timescales.
- ✓ **AI Scribe**: Approval of the Epic AI Scribe solution is progressing through Information Governance, with a pilot deployment in the Emergency Department planned following sign-off.
- ✓ **Copilot**: Copilot adoption continues to accelerate, with approximately 800 licences (80% of 1000 licenses) deployed across priority service areas and a programme of targeted training and enablement delivered in partnership with Clinical Leadership and Education team. The deliverable has been completed.
- ✓ **Benefits Dashboard**: Development of the Benefits Dashboard has been prioritised following a direct request from the Chief Executive Officer, with stakeholders currently defining and validating the required data sources. To support delivery of this strategic benefits realisation capability.
- ✓ **Modality Choice:** The Modality Choice initiative has been identified as a lower-priority, with a recommendation to defer implementation to a future OPFBC phase. This will be considered at the October ISG meeting.

Next Steps

- Data sourcing for benefits dashboard.
- Ongoing discussions with Epic about AI integration and AI Scribe tool.
- Seek to issue out remaining 200 co-pilot licences.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Number of Co-Pilot licences issued	0	1000	800	↑
% of clinical staff using digital dictation	TBC – Source data has been requested.			
% of staff completing digital skills programme	0	1500	405	↔
No of alternative applications in use where Epic is the primary platform	5	*0*	4	↔
MyCare adoption rate	0	50,000 *(end of year 1)*	44,000	↑
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 RAID for escalation in this reporting period.		

Assurance	Rating
Executive Sponsor Rating	Moderate

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

Torbay and South Devon NHS Foundation Trust

Delivered

Continued focus on recovering activity with additional support activities as required.
- ✓ Focus remains on data quality and reporting and supporting specialties to deliver our 26/27 operational plans.
- ✓ 3rd party specialist EPR support have been engaged to accelerate our validation activities.
- ✓ 3 stage process with our specialties to ensure delivery of our operational plans.

Continued monitoring and promotion of THRIVE training.
- ✓ Thrive training is underway, with Epic targets (2% of Nurses, 20% of Medics) in place for the end of October to meet the 'Good Install' criteria.
- ✓ 3.18% of Registered Nurses have already attended Thrive training.
- ✓ 16.16% of Medics have attended, with a further 14.12% booked before end of October.
- ✓ We aim to deliver over and above the Epic targets, including Admin staff in our plans.

Detailed understanding of PMO support of wider benefit types established.
- ✓ We have established that the PMO will not support non-cash and societal benefits, as their focus is purely on cash releasing benefits.
- ✓ Within the Epic team, we are now working to establish a parallel process for non-cash and societal benefits, to ensure we are able to meet our quarterly reporting commitments with Frontline Productivity.

Transition from Programme to BAU.
- ✓ The EPR Programme officially comes to an end on 30th September, at which point we will transition into a business-as-usual governance structure, overseen by the Devon Acutes EPR Board. This structure is largely in place, and development will continue over the coming weeks.
- ✓ Recruitment of key 'Devon Acutes' roles continues. Nursing, Midwifery and Allied Health Professional Information Officer (NMAHPIO) roles within TSD are filled, and the Medical Information Officer (MIO), Admin Information Officer (IO) and Benefits roles will be recruited to in due course.

Next Steps

- Further rollout of Thrive training will continue throughout October, with TSD on track to exceed Epic's 'Good Install' target.
- The proposed governance structure is scheduled for approval by sovereign organisations in October and November 2026.

Key Performance Indicators	Baseline	Target	Current Position	Trend
MyCare adoption rate	N/a	50,000 end Yr1	46,000	↑
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	£4,253k	↓
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

CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's (FYE)	Forecast Outturn £000's	26/27 Original WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
7 schemes	1,650,000	2,454,033	0	1,542,366	0	31.3	0	0	
4 schemes	3,300,000	632,723	0	404,268	0	2.07	0	6.52	
12 schemes	406,312	2,026,309	2,057661	2,163,063	18.7	20.78	17.85	25.49	
2 scheme	300,000	200,758	0	143,399	0.00	0.00	0.00	3.82	

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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

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5.1 Workforce Transformation

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ **Workforce Affordability and Vacancy Controls:** Following approval, a Trust-wide vacancy freeze has been implemented until December 2026, supported by strengthened recruitment controls and executive oversight. Recruitment and temporary staffing approvals are now limited to exceptional circumstances where there is a demonstrable patient safety risk or direct support for UEC and elective recovery. Internal redeployment, expressions of interest and workforce flexibility arrangements are being prioritised to manage vacancies and optimise existing workforce capacity.
- ✓ **Organisational Change:** Consultation on the People & Education Directorate redesign has concluded, with outcome letters pending completion of job matching panels. Planning for Phase 2 of the Operational Management Review (Band 8A-8C) is progressing and will be presented at Partnership Forum on 12 October, with formal consultation expected to commence shortly thereafter.
- ✓ **People Digital:** An independent review confirmed the Devon People Digital programme remains strategically aligned and has established strong digital, data and integration foundations. Recommendations include strengthening benefits realisation, governance and change management arrangements, alongside alignment with national programmes including TPS and FWS.

Next Steps

- Embed vacancy freeze and workforce affordability controls.
- Deliver Care Group workforce reduction plans.
- Complete implementation of the People & Education Directorate redesign.
- Commence consultation on the Operational Management Review Phase 2.
- Strengthen integrated workforce planning and governance
- Respond to People Digital review recommendations including benefits realisation, governance and TPS/FWS alignment.
- Continue recruitment, retention and temporary staffing reduction initiatives.

Key Performance Indicators	Baseline	Target	Current Position	Trend
CIP Workforce Reductions	N/A	56. 36 WTE	30.38 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)*
No RAID for escalation in this reporting period.		

Assurance	Rating
Executive Sponsor Rating	Moderate

CIP Scheme Ref	CIP Scheme Name	27-019	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	78,600	78,600	0	0	0	0	0	0	
27-019	People Digital Wave 2	418,000	418,000	163,671	163,671	7.95	7.95	4.09	7.95	
27-077	Operational Management Review	0	300,000	0	213,687	0.00	15.00	0	10.80	
27-077	Operational Management Review	0	963,000	256,690	256,690	0.00	18.69	6.28	6.28	
27-078	Corporate Management Review	2,340,000	1,077,000	476,185	476,185	55.36	16.37	9.21	9.21	
	Reduction in Management Costs	60,000	60,000	0	0	1.00	-1.00	0.00	0.00	

5.2 Cultural Transformation

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ **Learning Academy (LA):** Engaged key stakeholders to shape LA priorities, defined core programmes and reviewed the current offer, delivery effectiveness and future development opportunities. Working group established to oversee priorities (Leadership & management, Career conversations Behaviour framework).
- ✓ **Leadership & Management :** Progressed development of the leadership pathway and prepared supporting resources for the October launch of the Behavioural Framework, organisational change support for leaders and Restorative, Just and Learning Culture (RJLC) education.
- ✓ **Learning Culture Roadshows:** Developed plans for Learning Culture Roadshows to engage colleagues, gather feedback and promote a RJLC across the Trust. First dates in October, with plans to continue into Spring.
- ✓ **Data and Reporting:** Continued development of datasets and reporting arrangements to strengthen KPI monitoring, participation reporting and programme assurance NHS Staff survey (NSS) has launched.
- ✓ **Health and Wellbeing:** Developed pathway for musculoskeletal (MSK) physiotherapy for staff & progressed to advertising post.
- ✓ Sickness deep dive has begun to review localised long-term sickness & themes within teams with Human Resources Business Partners (HRBPs) support to deliver urgent mitigations.

Next Steps

- Deliver Learning Culture Roadshows.
- Deliver behaviour Framework support & education.
- Freedom to Speak Up (FTSU) service due to launch 12th October.
- Deep dive into sickness absence to ensure correct local mitigations supported by HRBPs.
- Continued recruitment to wellbeing posts & develop psychology pathway.

Assurance	Rating
Executive Sponsor Rating	Moderate

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 **Leadership: plan agreed; subgroup in place. Reach and impact data pending.**
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%	5.35	⬇
Staff engagement: Recommendation as a place to work	57%	62%	Data available March 2027 (NSS publication)	
Staff Survey response rate	38%	47%	Data available March 2027	
Global majority representation (WRES) *Increase band 6-7* *Increase band 5-6* *(WDES)*	 5.97% 10.36% 8.22% 5.16%	 13.3% 13.3% 7.62% 7.62%	 5.94% 10.93% 8.22% 5.16%	 ⬆ ⬌
To be agreed with GS FTSU provision	Awaiting Data			

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

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	24,000	24,000	0	0	2.73	0	0	0	
27-020	Education & Training - Cost Reduction	150,00	150,000	69,628	69,628	0	2.70	2.00	2.00	
27-035	Temporary Staffing	1,400,000	1,400,000	0	1,400,000	4.14	4.14	0.00	46.20	

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6.0 Strategic Enablers
Senior Responsible Owner – James Corrigan, CFO

Securing the essential foundations for transformation

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6.1 One Devon Shared Services - Finance

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The overall project assurance remains Limited rather than Inadequate, reflecting the fact that implementation planning is progressing and a number of delivery options remain under active consideration. Multiple potential go-live dates, together with associated contingency arrangements, are being evaluated to ensure the selected approach meets the requirements of both TSD and SBS while maintaining alignment with wider Devon Trust implementation timelines. Detailed project milestones and delivery plans will be finalised and updated once the preferred go-live date has been formally agreed.
- ✓ Confirmation of the revised SBS go-live date is required to enable programme re-planning, align dependent workstreams, and establish a clear and deliverable milestone schedule.
- ✓ Following system-wide concerns across the Devon Trusts regarding programme readiness and confidence in SBS's ability to deliver key milestones within agreed timescales, a collective decision was taken on 28/08/2026 to defer the SBS go-live beyond 01/10/2026. A revised go-live date is currently under review and is expected to be agreed through the Devon SBS Programme Board on 16/10/2026, providing a clearer basis for delivery planning and dependency management.
- ✓ The deferral of the SBS go-live date has delayed mobilisation of the One Devon Finance Team, with workforce transition activity now dependent on confirmation of the revised implementation timetable. This introduces a risk to resource alignment and the delivery of associated programme milestones until a revised go-live date is agreed.
- ✓ TSD continues to progress SBS readiness activity, including completion of information requests and targeted data cleansing, to maintain delivery momentum and ensure organisational readiness for mobilisation once the revised go-live date is confirmed.

Next Steps

- The revised SBS go-live date has been confirmed for April 2027, enabling the programme to re-baseline delivery plans, align key dependencies and progress implementation readiness. TSDFT will continue data quality, cleansing and submission activity to maintain programme momentum and support a successful go-live.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Completion of critical path milestone	N/A	13	Previous reported data has stopped and will be updated when new SBS go live date is agreed.	
Testing status	N/A	88%		
One Devon Shared Service Programme KPI's	N/A	29		

RAID Group	Score/ Category	Mitigation / Description *(Risks, Issues) (Assumptions, Dependencies)*
Issue	Critical	System not ready resulting in delay of go live date from 1st October.

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

NHS England has published the latest NHS Oversight Framework segmentation and league table data for NHS providers.
Under the revised framework, we have been placed in Segment 3, compared with Segment 4 in the final publication under the previous methodology. Our position in the acute and specialist trust league table is joint 101st out of 134 trusts, compared with 102nd previously.
NHS England has advised that comparisons with previous publications should be treated with caution because the framework, methodology and measures have changed for 2026/27. Quarter 1 is being treated as the baseline against which future performance will be assessed under the revised approach. Q2 2026/27 segmentation is due to be published in November – date not yet confirmed

Torbay and South Devon NHS Foundation Trust

NOF performance summary - scores range from 1.00 (highest rating) to 4.00 (most in need of improvement)

Average score	Financial deficit
2.67	**Yes**
Below Average and/or Financial Deficit	
Likely range: 2.29 to 3.05	

Segment	Provider rank
3	**101**
Below Average and/or Financial Deficit	out of 134 providers
Capped due to financial deficit	Likely range: 54 to 130

Domain quartiles

All metrics for this provider grouped by NOF domain. Each metric receives a score between 1 and 4, with 1 being the highest rating.

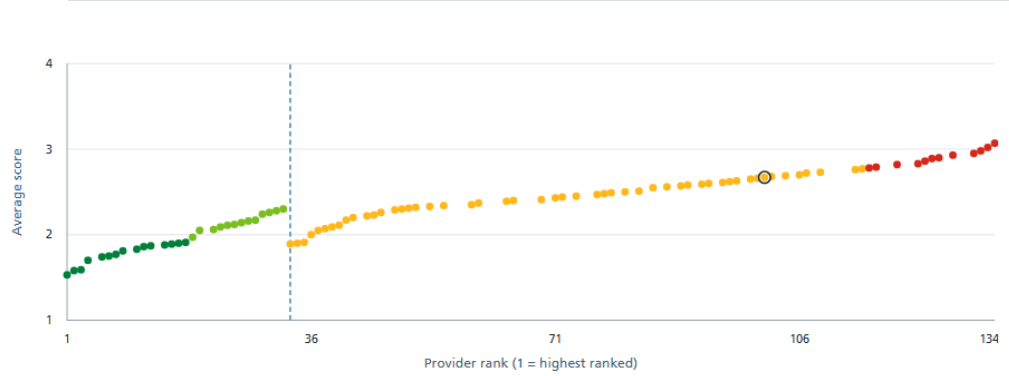
Access to services	Patient safety	Finance, productivity and innovation
Quartile 4 Lowest-scoring 25%	Quartile 2 Second-highest-scoring 25%	Quartile 4 Lowest-scoring 25%

People	Experience of care	Effectiveness of care and population health
Quartile 2 Second-highest-scoring 25%	Quartile 4 Lowest-scoring 25%	Quartile 4 Lowest-scoring 25%

Average score by provider rank placement

Each point represents a provider, plotted by rank and average score. This provider is highlighted to show where it sits relative to peers.

Chart | Data



Selected organisation is marked with its segment colour, a white gap, and a black outline.

Performance Reporting - Governance

Torbay and South Devon NHS Foundation Trust

System performance governance and reporting:

Monthly Devon System Performance Review Meetings continue to take place.

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

- Urgent and Emergency care remains behind plan but showing performance improvement across key measures in September with further improvement in first half of October: September 4-hour performance was 71.5% against a 76.0% trajectory; Type 1 ED performance was 59.4% and the highest ED performance since August 2025.
- Ambulance flow improved: 548 handovers exceeded 45 minutes, down from 887 in August. Average handover time was 39 minutes 35 seconds from 54 minutes in August.
- Demand and flow remain pressured: September activity reached 11,126 ICO attendances, while pre-noon discharges were 12.5% against the 33% target and pre-5PM discharges were 68.1%.
- Corridor care remains elevated at 1,015 episodes in September. While significant amounts of work are still required to enable and sustain this objective, improvement has been demonstrated as a result of the actions undertaken to date.

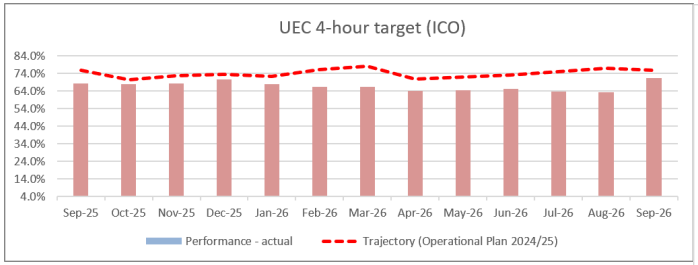
National Oversight Framework– Urgent and Emergency Care Performance Summary

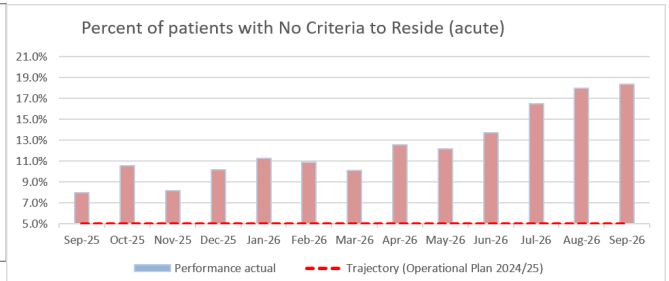
Torbay and South Devon NHS Foundation Trust

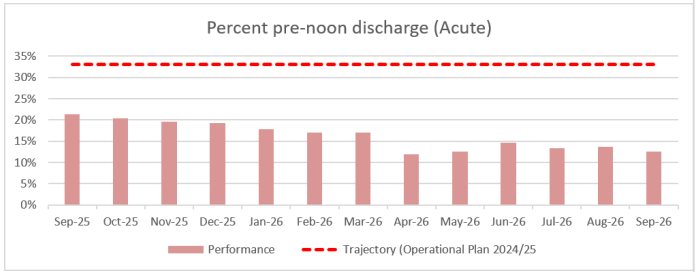
Trajectories have been agreed as part of the 2026/27 Operational Plan submission; monthly performance RAG ratings are based on these trajectories. Data in bold is nationally reported data.

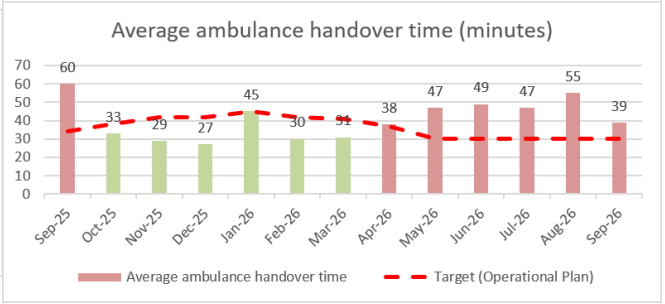
INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															
Data RAG rated against monthly Operational Plan trajectory **Bold number = national data**	Target March 2027	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Urgent and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)			1823	810	624	559	1283	621	755	953	1394	1365	1338	1612	1020
Ambulance handovers - time lost over 15 mins - Plan										641	676	623	681	674	662
Average handover time (mins) - Actual			60	33	29	27	45	30	31	38	47	49	47	55	39
Average handover time (mins) - Plan	30 mins		38	42	42	45	42	41	37	30	30	30	30	30	30
Total average time in ED (hours/minutes) - Actual	Reduction		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		655	585	549	520	918	740	734	676	839	805	950	1000	903
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan										394	655	469	423	394	606
Percentage of patients waiting over 12 hours in ED - Actual	7.7%		**9.7%**	**8.5%**	**8.3%**	**7.5%**	**13.6%**	**12.1%**	**10.6%**	**9.8%**	**11.7%**	**11.1%**	**12.9%**	**13.5%**	**12.2%**
Percentage of patients waiting over 12 hours in ED - Plan			8.2%	9.9%	8.4%	7.2%	7.0%	7.0%	6.1%	5.4%	8.3%	6.2%	5.2%	4.9%	8.5%
UEC 4-hour target (RAG against local trajectory to national target) - Actual	82%		**68.3%**	**68.0%**	**68.3%**	**70.8%**	**67.9%**	**66.4%**	**66.6%**	**64.2%**	**64.7%**	**65.3%**	**63.9%**	**63.4%**	**71.5%**
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%	77.0%	76.0%
% patient discharges pre-noon - Actual			21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%	13.6%	12.5%
% 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			8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%	18.0%	18.4%
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









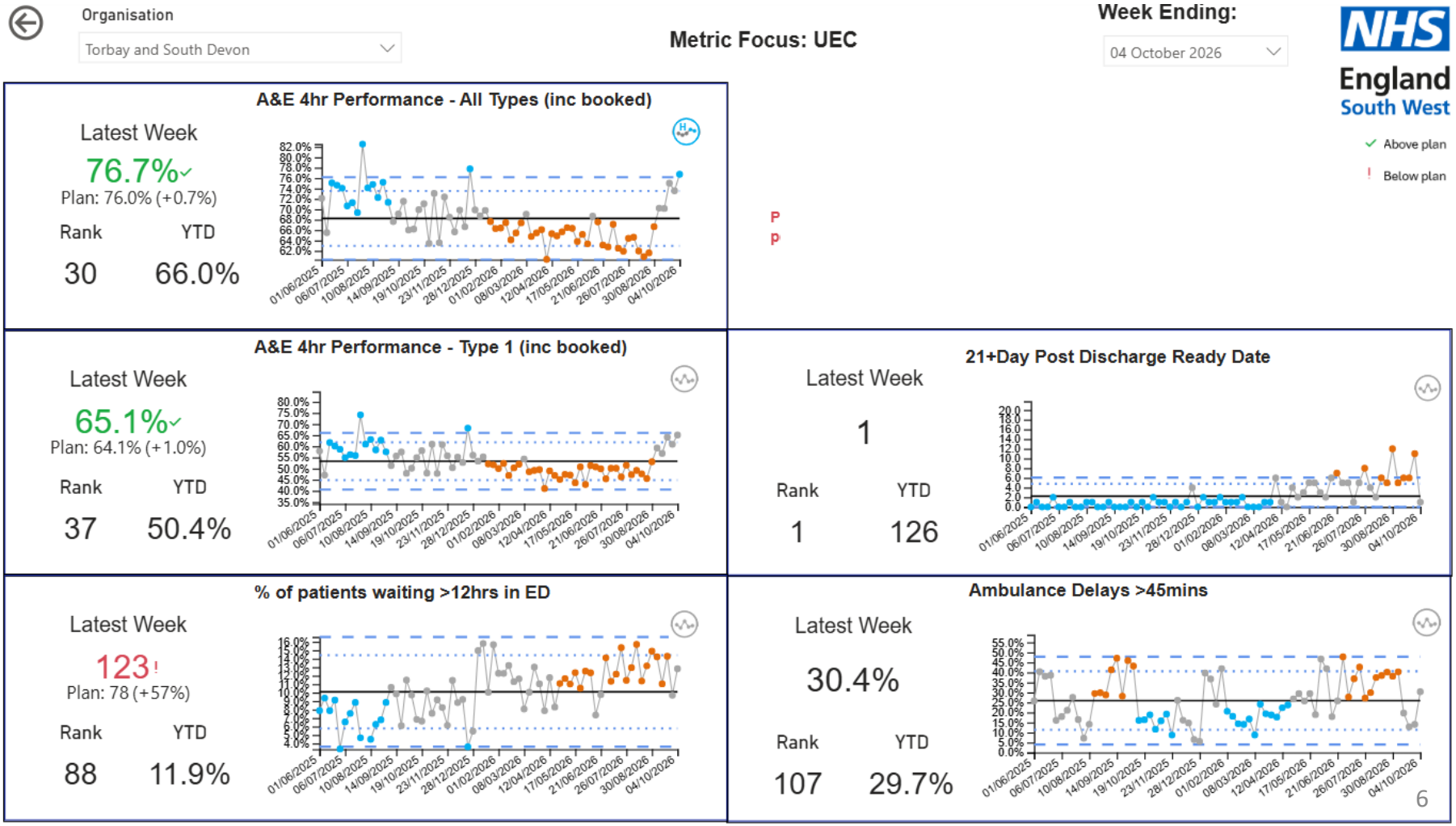
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Urgent and Emergency Care Performance Summary - NHS England monitoring report

Torbay and South Devon NHS Foundation Trust

The reports below have been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key UEC metrics. These metrics form the basis of the weekly performance reviews with NHS England.

The latest weekly report includes data up to week ending 4 October 2026 and shows that the Trust met the Operational Plan trajectories for A&E 4-hour performance for all types and type 1. Ambulance handover delays over 45 minutes have decreased from last month from 881 to 548 patients; the most recent weekly ranking puts the Trust at 107 out of 123 trusts from rank of 120 at the time of reporting last month.



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

Torbay and South Devon NHS Foundation Trust

Performance

The total number of ambulance conveyances to the ED in September was 2,478 (2,402 in August 2026). September's average ambulance handover was 39mins 35secs. The number of handovers over 45mins decreased from 887 in August to 548 in September.

Average handover time – rolling 30 day (as 14 October 2026)

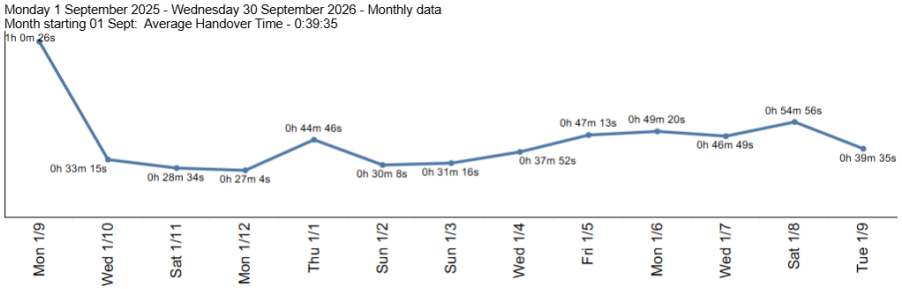
Ambulance Trust	Site Name	
South Western	Derriford Hospital	1:02:11
South Western	Royal United Hospital	0:58:15
South East Coast	St Bartholomew's Hospital	0:47:35
South Western	The Great Western Hospital	0:36:11
South Central	Royal Bournemouth Hospital	0:35:04
South East Coast	Queens Hospital	0:34:23
South Western	Royal Bournemouth Hospital	0:32:48
South Western	Torbay Hospital	0:31:25
South Western	Royal Devon & Exeter Hospital (w..	0:31:01
South Western	Salisbury Health Care NHS Trust	0:27:56
South Western	Poole Hospital	0:27:46
South Western	Royal Cornwall Hospital (treliske)	0:27:41
South East Coast	St Peter's Hospital	0:26:12
South East Coast	Kingston Hospital	0:25:33
South Western	Yeovil District Hospital	0:25:22
South East Coast	Princess Royal University Hospital	0:25:21
South East Coast	University College Hospital	0:25:18

Operational update

September continued to see sustained operational pressure across urgent and emergency care pathways, with ICO attendances reaching 11,226.
Length of stay in the Emergency Department has remained a challenge with 146 patients with a stay greater than 24 hours and 6 patients greater than 48 hours.

- Corridor Care Programme delivery continues through the four pillars: Right Care, Right Pathway, Right Flow and Right Coordination.
- Current focus is improving patient flow, reducing delays and ensuring patients access the right care setting first time.
- Targeted actions are underway to reduce ambulance handover delays and improve patient throughput across the UEC pathway.

Average ambulance handover time



Actions to complete next month

Right Care: Strengthen early clinical review, streaming and specialty referral processes.
Right Pathway: Maximise utilisation of SDEC, UTC and alternatives to admission.
Right Flow: Improve length of stay management and discharge planning to increase capacity.
Right Coordination: Enhance operational oversight, demand and capacity planning, and workforce deployment.

Risks/issues

• High demand and capacity constraints continue to impact ambulance handover performance.
•Flow limitations across inpatient pathways remain a key challenge.
•Delivery of improvement actions requires sustained focus across all four programme pillars.
•System pressures may affect the pace of performance recovery.

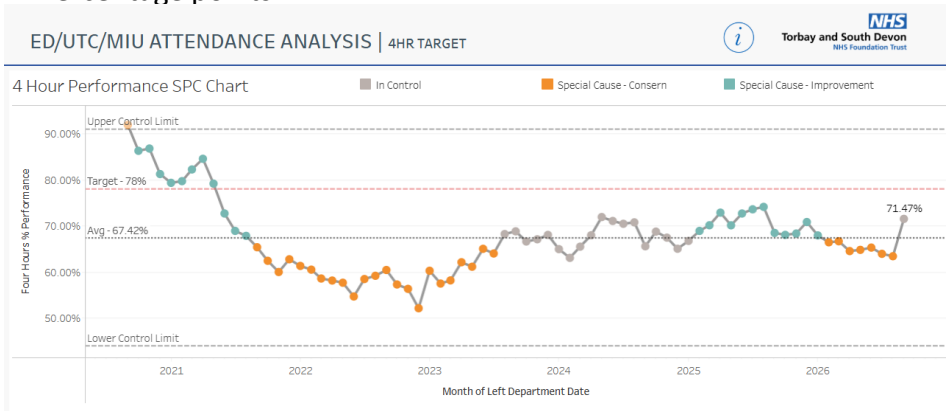
Exception report: 4-hour ED target: - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

	Sept 2025	Sept 2026	% difference
MIU/UTC attendances	3464	3743	+8.0%
MIU/UTC performance	99.9%	94.9%	-5.0%*
ED (type 1) attendances	7060	7383	+4.6%
ED (type 1) performance	52.9%	59.4%	+6.5%*
ICO attendances	10524	11126	+5.7%
ICO performance	68.3%	71.5%	+3.2%*

- Percentage points



Operational update

4-hour performance for the month stands at 71.5% against a trajectory of 76.0%, this is an improved position and the best performance for 12 months. The ICO had 11,126 attendances; the Emergency Department recorded 7,383 attendances.
October's month-to-date is showing a performance of 77.3% (as at 118/10/26)

- Improvement activity continues through the Corridor Care Programme's four pillars: Right Care, Right Pathway, Right Flow and Right Coordination.
- Focus remains on improving patient navigation, strengthening alternatives to admission and reducing ED crowding.
- Actions across acute, community and urgent care services are supporting improved flow and recovery of performance standards.

Actions to complete next month

- **Right Care:** Improve early assessment, streaming and referral decision-making.
- **Right Pathway:** Expand capacity within SDEC, UTC and ambulatory care pathways.
- **Right Flow:** Reduce length of stay and accelerate discharge to improve bed availability.
- **Right Coordination:** Strengthen whole-system planning, escalation management and workforce resilience.

Risks/issues

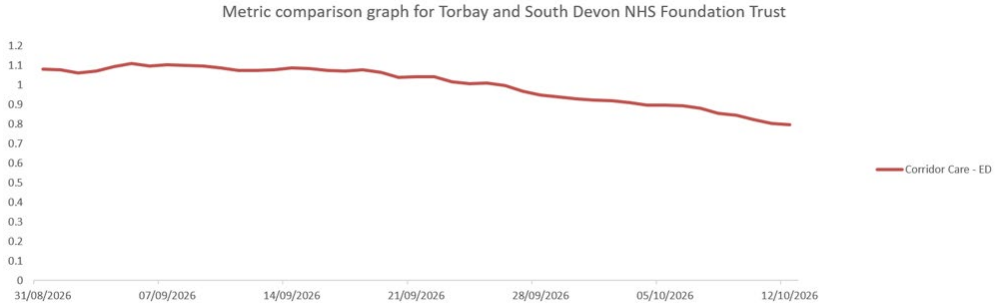
- Sustained demand continues to impact delivery of 4-hour performance standards.
- Capacity pressures and patient boarding remain significant flow constraints.
- Progress is dependent on continued delivery across all four Corridor Care Programme pillars.
- System-wide coordination is required to maintain momentum and support sustainable improvement.

Exception report: Corridor Care

Torbay and South Devon NHS Foundation Trust

Performance

The Trust has experienced a decrease in the number of patients waiting longer than 45 minutes in the corridor or a non-clinical space.



A key driver for improving daily patient flow and reducing corridor care is earlier in the day discharge and the number of beds occupied with no criteria to reside.

- The percent of pre-noon discharge for September is showing at 12.5% (target 33%) and pre-5PM at 68.08%.

- The number of beds reported as occupied with patient classified as No criteria to reside remain high at 16.5% (Target 5%) and around 66 beds

There remain clear opportunities to impact patient flow through improvement of these metrics

Operational update

The Trust has developed its response to eliminating corridor care from a broad set of improvement ideas into an integrated Urgent and Emergency Care portfolio spanning the full patient pathway. Four connected programmes now provide clear governance, executive ownership and escalation arrangements.

- **Right Care:** Right decision first time.
- **Right Pathway**: Alternative pathway first, admission last.
- **Right Flow**: Keeping patients moving through their care.
- **Right Coordination**: Creating the optimum conditions for flow.

The portfolio comprises 29 projects, with most reported as on track; however, it remains weighted towards planning and has not yet consistently demonstrated measurable benefits at scale.

While significant amounts of work are still required to enable and sustain this objective, improvement has been demonstrated as a result of the actions undertaken to date.

Actions to complete next month

Four flagship projects have been selected for accelerated delivery: ED non-admitted performance; SDEC and the Unscheduled Care Village; expansion of frailty services; and length of stay. **Key milestones include a 10% improvement in non-admitted performance by 31 October 2026 (already achieved) , Phase 1 of the SDEC model with the relocation of discharge lounge and opening of the emergency village (Moves commenced as planned on 15 October 2026),** progression of Harbour frailty expansion towards January 2027, and embedding twice-weekly length-of-stay reviews with evidence of impact

Risks/issues

- 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

- Elective recovery remains behind trajectory, with only 1 of 7 Month 6 indicators met. Latest published weekly RTT performance (week ending 11 October 2026) was 58.9% against a 63.5% plan, ranking 116th of 134 trusts.
- The RTT waiting list is within plan at 31,358 against 33,885, but the post-Epic reduction remains provisional and subject to data-quality validation.
- Long waits have worsened: provisional August figures show 21 patients over 78 weeks, 160 over 65 weeks and 1,241 over 52 weeks, concentrated in T&O, Ophthalmology and ENT.
- First-outpatient performance remains off plan: the latest weekly result was 63.6% against 66.9% plan, ranking 116th; clinic capacity has not fully recovered to pre-Epic levels.
- Cancer performance is improving but remains off track: Sept FDS was 56.4% against target 82.9%, 62-day urgent referral to treatment was forecast at 65.0% against target 80%, and the 62-day backlog was 264 patients (8.9%).

On-going actions

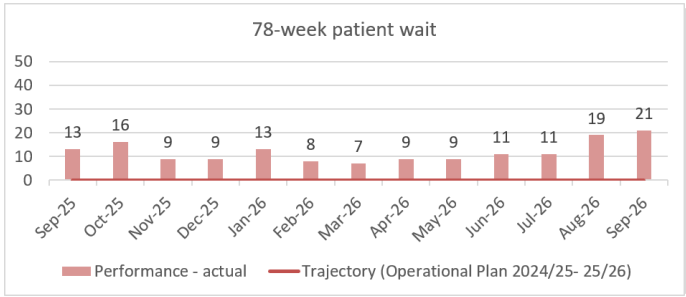
- Stabilise Epic activity and data validation while supporting teams to restore outpatient productivity.
- Continue targeted insourcing and capacity recovery in Dermatology, Gynaecology, Breast and long-wait specialties.
- Progress theatre and outpatient recovery, recruitment and signed-off specialty recovery plans.
- Maintain weekly breach reviews, GIRFT-led productivity oversight and close engagement with ICB and NHS England.

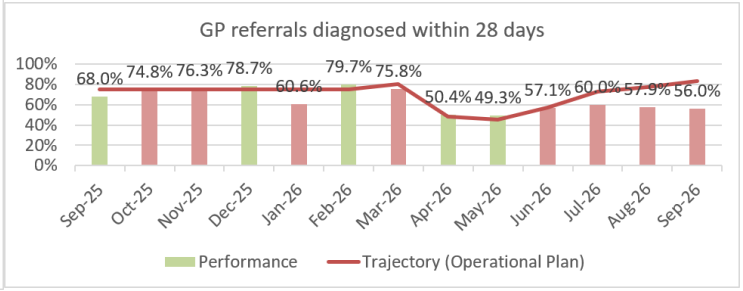
National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

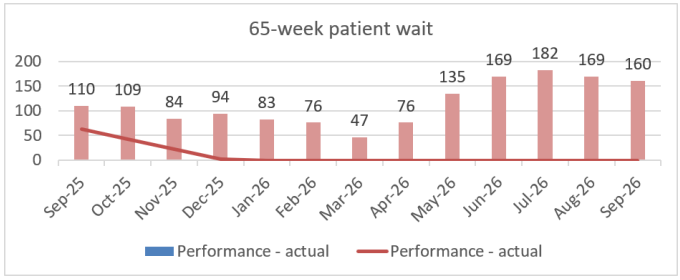
Torbay and South Devon NHS Foundation Trust

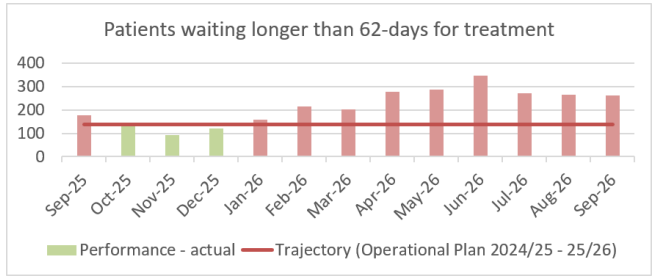
INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Data RAG rated against monthly Operational Plan trajectory **Bold number = national data**	Target March 2027	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Elective Care															
RTT 78 week wait incomplete pathway - Actual			13	16	9	9	13	8	7	9	9	11	11	19	21
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			110	109	84	94	83	76	47	76	135	169	182	169	160
RTT 65 week wait incomplete pathway - Plan	0		43	23	3	0	0	0	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	647	607	663	604	607	600	799	993	1088	1317	1249	1209
RTT 52 week wait incomplete pathway - Plan	292		673	586	505	449	383	327	268	805	941	1088	1009	929	850
RTT % Incomplete pathways <18 wks - Actual			**70.4%**	**69.3%**	**68.7%**	**67.5%**	**67.0%**	**66.8%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	58.5%
RTT % Incomplete pathways <18 wks - Plan	73.8%		64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%	57.0%	59.0%	61.0%	62.0%
RTT Wait for first appointment <18 weeks - Actual			73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	62.4%	62.6%	60.7%	62.9%
RTT Wait for first appointment <18 weeks - Plan	74.0%		67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%	67.4%	66.8%	68.0%
Cancer: 28-day FDS - Actual			**67.3%**	**75.7%**	**76.2%**	**78.3%**	**60.6%**	**79.7%**	**75.7%**	**48.0%**	**45.5%**	**57.1%**	**58.5%**	**60.6%**	56.0%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%	57.4%	73.0%	77.0%	82.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			**63.2%**	**70.4%**	**71.1%**	**79.8%**	**75.2%**	**67.1%**	**60.1%**	**58.5%**	**48.9%**	**53.6%**	**57.9%**	**70.0%**	65.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%	78.8%	79.2%	79.9%	79.5%
Cancer: No of patients waiting >62 days to start treatment - Actual			176	132	91	119	159	214	201	276	288	347	272	276	264
Cancer: No of patients waiting >62 days to start treatment - Plan															
Cancer: % of patients > 62 days to start treatment - Actual			7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	12.0%	8.9%	9.5%	8.9%
Cancer: % of patients > 62 days to start treatment - Plan															
Diagnostics - proportion waiting over 6 weeks - Actual			**36.8%**	**29.4%**	**28.4%**	**30.4%**	**35.8%**	**30.6%**	**37.4%**	**39.4%**	**34.6%**	**25.4%**	**23.1%**	23.7%	21.5%
Diagnostics - proportion waiting over 6 weeks - Plan	14.9%			5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%	29.2%	27.7%	25.6%	23.9%	21.4%









RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

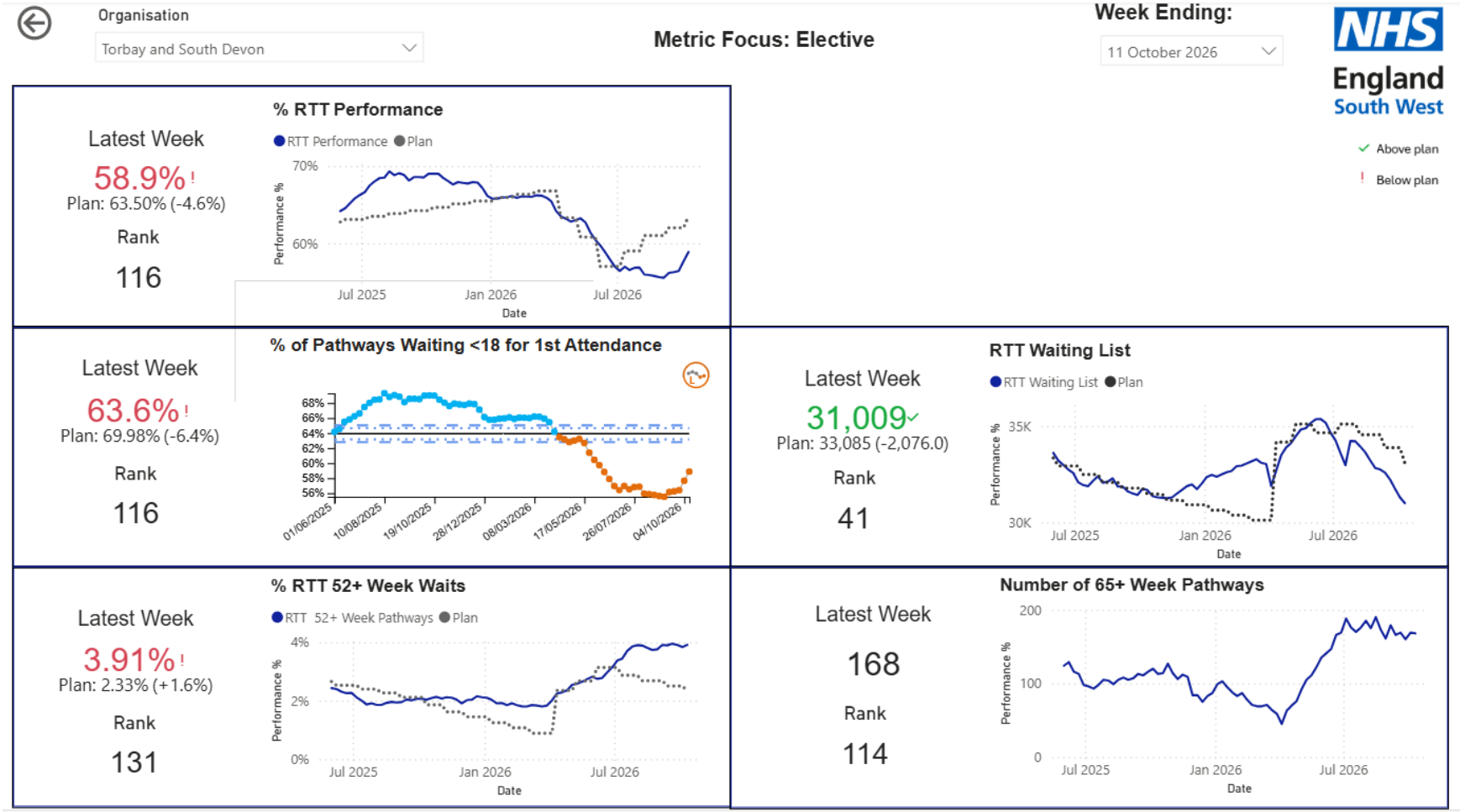
Trajectories have been agreed as part of the 2026/27 Operational Plan submission.

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 6 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.



12

Data source: NHSE SW Weekly Performance Dashboard

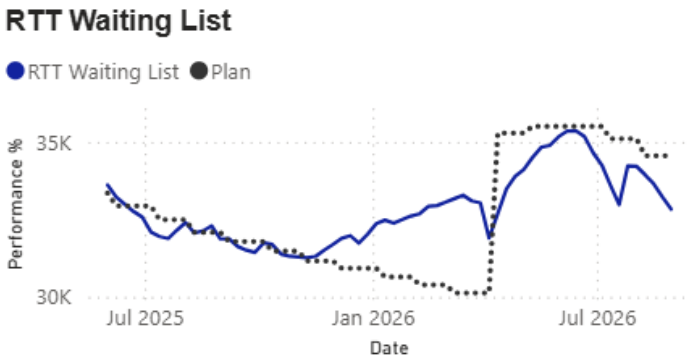
Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

Performance

The implementation of Epic has impacted on activity levels which is reflected in the long waits seen.

	September 2025	September 2026
78 weeks	14	21
65 weeks	100	160
52 weeks	623	1241



Metric Focus: Elective - NHSE SW Weekly Performance Dashboard - Power BI

Operational update

78 week: At the end of September (provisional figures) there are 21 breaches; 16 sitting within T&O and 5 within Ophthalmology
65 week: In September (provisional figures) there were 160 breaches – with the majority sitting within T&O (83), Ophthalmology (53) and ENT (12)

Weekly meetings to review breaches and plan required actions continues.

Total waiting list size: The total waiting list has decreased to 31,358 on 30th September (Provisional) following the new Electronic Patient Record go live on 3rd April.
The waiting list has stabilised with the recent weeks data showing that the cohort < 18 weeks remaining stable having been a factor in the reported performance deterioration and the cohort > 18 weeks not starting to reduce. Overall this is a material change to previous months and sets the basis of RTT recovery plans going forward that will see 1. full recovery to pre epic levels of activity 2. additional activity over current run rate 3. continued validation of the waiting list pathways and Data Quality assurance.

Actions to complete next month

- Stabilisation of EPIC – activity stabilisation and validation (MBI commenced validation of 6,00 pathways) 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.
- Recovery plans now signed off and to be set into BAU scheduling and performance tracking.

Risks/issues

- Full recovery of outpatient capacity to pre-Epic levels remains a challenge. Clinicians are being supported to access Thrive training to ensure personalisation and functionality in EPIC is used to support increased productivity.
- 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 to agreed posts to deliver additional capacity and insourcing where agreed.
- Sickness in key areas such as Ophthalmology, Colorectal and ENT.

Exception report: RTT First Outpatient – Elective Recovery

Torbay and South Devon NHS Foundation Trust

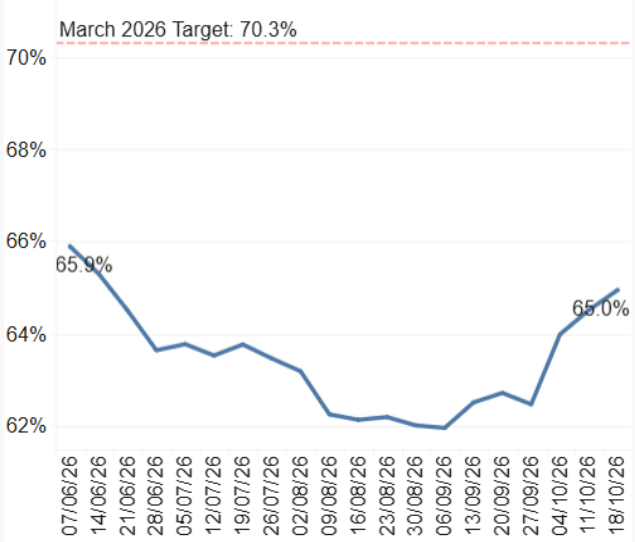
The Outpatient Improvement Group will maintain productivity oversight and drive forward improvements to ensure capacity is optimised and Getting it Right First Time (GIRFT) benchmarks are used to inform plans.

The Trust achieved 62.9% in September (as at 4/10/26) against the trajectory of 68% 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.
Formal recovery plan in place across Cancer, RTT, and Diagnostics.
Activity levels have been improving month on month although are behind the original planning assumptions to restore pre-EPIC levels of activity by end of M3. Recovery plans are under constant review to recover the loss of activity over the remainder of the year. The table below shows the number of patients waiting over 18 weeks for 1st Op attendance. Additional insourcing is being used to support the areas with the highest number of pathways across including – Ophthalmology, ENT, oral Surgery, T+O, Dermatology and Cardiology

WLMDS MONITORING | WAIT TO FIRST ACTIVITY

Torbay and South Devon NHS Foundation Trust

Proportion of pathways waiting 0-18 weeks for a 1st activity



Proportion of pathways waiting 0-18 weeks for a 1st activity at 18/10/2026

Treatment Function	1st Activity	0-18 Weeks	18+ Wee..	Performan..
130 - OPHTHALMOLOGY	3,895	1,963	1,932	50.4%
120 - ENT	2,542	1,178	1,364	46.3%
140 - ORAL SURGERY	1,828	950	878	52.0%
110 - TRAUMA & ORTH..	1,763	1,123	640	63.7%
101 - UROLOGY	1,104	644	460	58.3%
330 - DERMATOLOGY	2,049	1,711	338	83.5%
320 - CARDIOLOGY	1,188	880	308	74.1%
191 - PAIN MANAGEME..	450	213	237	47.3%
340 - RESPIRATORY M..	813	609	204	74.9%
400 - NEUROLOGY	807	606	201	75.1%
302 - ENDOCRINOLOGY	484	298	186	61.6%
502 - GYNAECOLOGY	799	621	178	77.7%
410 - RHEUMATOLOGY	515	382	133	74.2%
430 - GERIATRIC MEDI..	198	93	105	47.0%
106 - UPPER GASTROI..	420	321	99	76.4%
104 - COLORECTAL SU..	497	402	95	80.9%
214 - PAEDIATRIC TRA..	158	74	84	46.8%
650 - PHYSIOTHERAPY	463	403	60	87.0%
216 - PAEDIATRIC OPH..	133	103	30	77.4%
811 - INTERVENTIONAL..	25	0	25	0.0%
420 - PAEDIATRICS	184	160	24	87.0%

Wait to first activity seeks to increase the proportion of pathways

Exception report: Cancer Waiting Time Standards

Torbay and South Devon NHS Foundation Trust

Performance

	May 2026	June 2026	July 2026	August 2026	September 2026
28-day Faster Diagnosis Standard	45.5%	57.1%	58.4%	60.6%	56% (Forecast)
31-day treatment	92.8%	93%	93%	94.7%	95% (forecast)
62-day cancer RTT	48.9%	54%	57.6%	70.0%	65% (forecast)
62-day backlog	288 (8.6%)	347 (12.0%)	300 (8.7%)	287 (9.7%)	264 (8.9%)

***Forecast figures**

Faster Diagnosis Standard (FDS): In September, the current position is 56%. We saw an improvement from May to August, but capacity challenges in Dermatology have been the main driver in the September decline. We have seen recovery in many specialties, notably Breast and Gynaecology although they still remain below plan.

FDS Performance	August	September
Breast	74%	82% ⬆️
Gynaecology	47%	55% ⬆️
Skin	55%	37% ⬇️

62-day Cancer Referral to Treatment: We finished August at after a positive run of performance at 70% but see a downturn in September, currently forecast at 65%. Behind this the Backlog has continued to improve, but a significant proportion remains within Skin.

Actions to complete next month

- Skin: In-house Photohub clinics began on 23 September, with expansion planned through October to support tele-dermatology triage and prioritisation of higher-risk lesions. Additional insourcing is planned from October and a locum extension provides additional capacity. Reprioritisation of recovery funding is allowing more capacity to be procured.
- Gynaecology: Peninsula Cancer Alliance has awarded £65,000 to support cancer pathway recovery. This will allow for approximately 200 additional ultrasound scans and 100 hysteroscopy procedures, aimed at reducing the diagnostic backlog and improving Faster Diagnosis Standard performance.
- Breast: Waiting times have improved through September, with additional GP sessions, timetable optimisation, expanded nurse-led clinics and increased radiology capacity. Appointments are now being booked within two weeks.

Risks/issues

- Skin baseline capacity is below what is required for the ongoing demand. Note improvement actions above.
- Regular meetings and communication with ICB/NHSE to mitigate regulatory risk.

Operational Performance Indicators - dashboard of key metrics

NHS Torbay and South Devon NHS Foundation Trust

Key

↑ = **Performance improved from previous month** ↓ = **performance deteriorated from previous month** ↔ = **no change**

	Not achieved 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 Patient Safety Summary

Temporary Escalation spaces (corridor care) and patient safety incidents
Nine corridor-care incidents were reported in September (no change); none caused moderate or severe harm. One report involved a patient who died from cardiac arrest while in the corridor; the death was not directly attributed to corridor care.

Incidents: Discharge/ transfer of care
There has been a reduction in harms rated as 'death' and an increase in 'severe' incidents in month, but the overall trend of incidents classed as moderate or above has seen a decrease in month. This data is being validated.

Mortality surveillance
In September, the Trust implemented the benchmarking tool HED (Healthcare Evaluation Data) being a tool to support benchmarking against mortality, patient safety and operational efficiencies. The latest Data demonstrates the Trust levels remain within expected. It is noted however that there is a trend toward National average in the recent data, a full review is underway.

Stroke care
Headline data suggests an improved picture across all time critical stroke standards for the month of September. Further work is underway with a 6wk test of change SOP with the plan to protect three stroke beds to improve patient care and the associated KPI's. This work started on 1st October.

Maternity
For September there were no stillbirths, neonatal deaths or late fetal losses reported. There was 1 severe incident reports, an increase of 1 from august in relation to a missed Anti D which is and under review.

Multiple Sclerosis Service
An individual PSII is being undertaken, and broader services are being reviewed, ongoing work continues.

Infection Control
Rates C-Diff are within expected target, 9 below Trust threshold. E.Coli is at 32 which falls outside of the Trust threshold by 2 for September, however, to note of these 32 25 are classified as COCA which is not directly reflective of care provided by the Trust. Both areas have robust action plans in place.

Feedback and engagement
3-day patient acknowledgement has seen an improvement with ongoing work to address the previous backlog of incomplete investigations.

Safer Staffing
September data is within the NHSE suggested tolerance of 80-120% but registered fill rate fell out the Trusts tolerance of 90-110% fill rates from 90.8% to 89.7% for day shifts moving the position from green to amber. Staffing cover is monitored through Trust staffing meetings.

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.

From the recent CQC visits (September and October) awaiting formal letter regarding outcomes/findings. Evidence as requested submitted as required.

Paediatric Inspection August 2024
The Paediatric action plan (Louisa Cary) is currently reporting as completed. An evidence review of the final actions closed is currently in progress and due to report to the end of September 2026 meeting.

From the recent CQC visits (September) awaiting formal letter regarding outcomes/findings. Evidence as requested submitted as required.

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 end of September 2026 meeting.

Adult Social Care CQC Action Plan
All actions currently on track or not due.

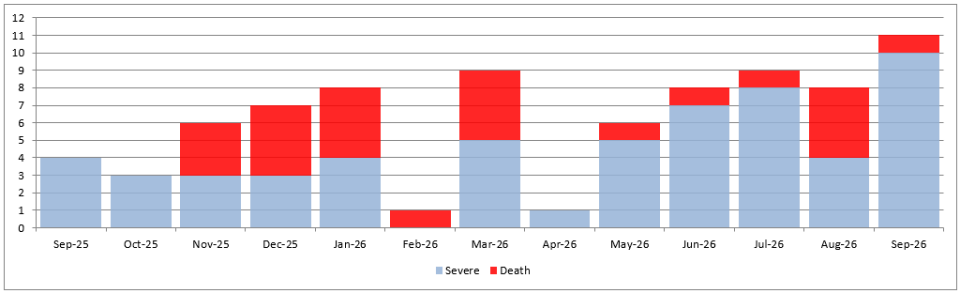
Areas to note and escalate.
- Await outcome letters of recent two visits in Sept and Oct 2026 of surgical services and Intensive Care.
- Regulation 29A received from Octobers visit in relation to Fire standards which is currently being responded to and worked through with the ongoing Tower works.

Quality and Safety exception reports – Reported incidents

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Severe	4	3	3	3	4	0	5	1	5	7	8	4	10
Death	0	0	3	4	4	1	4	0	1	1	1	4	1



Patient Safety Incidents reported as severe harm or death

There were 10 incidents of severe harm and 1 incident of death reported in September 2026.

[Death] Patient brought to ED by ambulance, receiving care in the corridor, had a cardiac arrest, subsequently died

[Severe] Child abnormal ECG, cardiac arrest. For PSR

[Severe] Delay in follow up following CT, For PSR

[Severe] Processing issue of anti-D for a pregnant woman. SHOT report

[Severe] Delay to ophthalmology follow-up. For AAR

[Severe] Pre-term delivery – approx. 24 weeks. For PSR

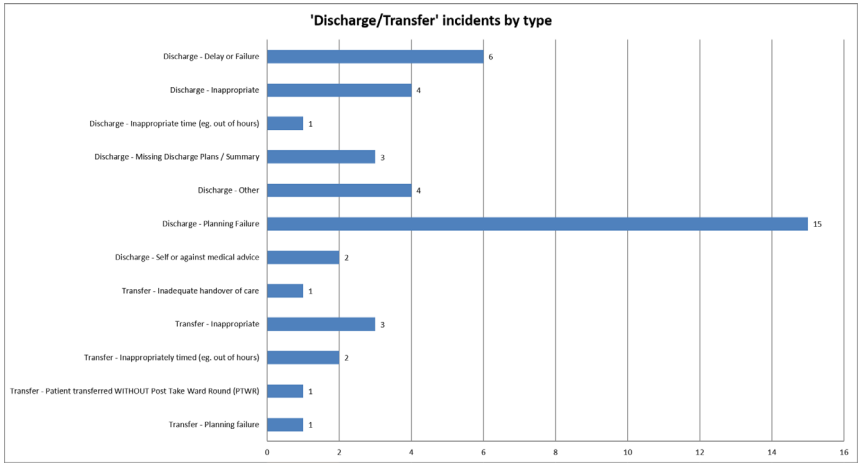
[Severe] Delay to ophthalmology follow-up. For AAR

[Severe] Fall with fracture. For falls AAR

[Severe] Fall with #NOF. For falls AAR

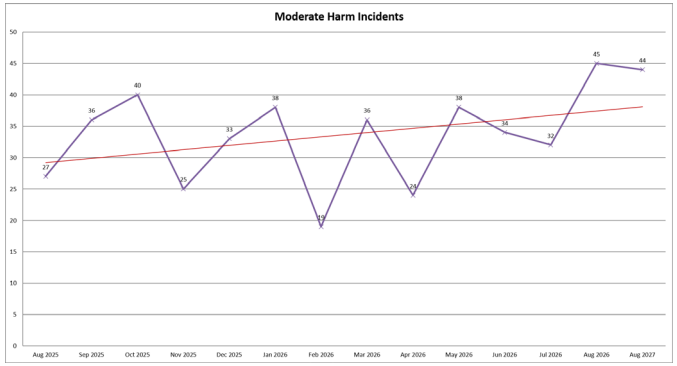
[Severe] Fall with #NOF. For falls AAR

[Severe] Fall with fracture. For falls AAR



Moderate Harm: All Patient Safety Incidents

44 incidents were categorised as having moderate harm in September, a slight decrease from 45 in August. Over the last 12-months the previous high was 41, with a low of 19



Areas to note and escalate

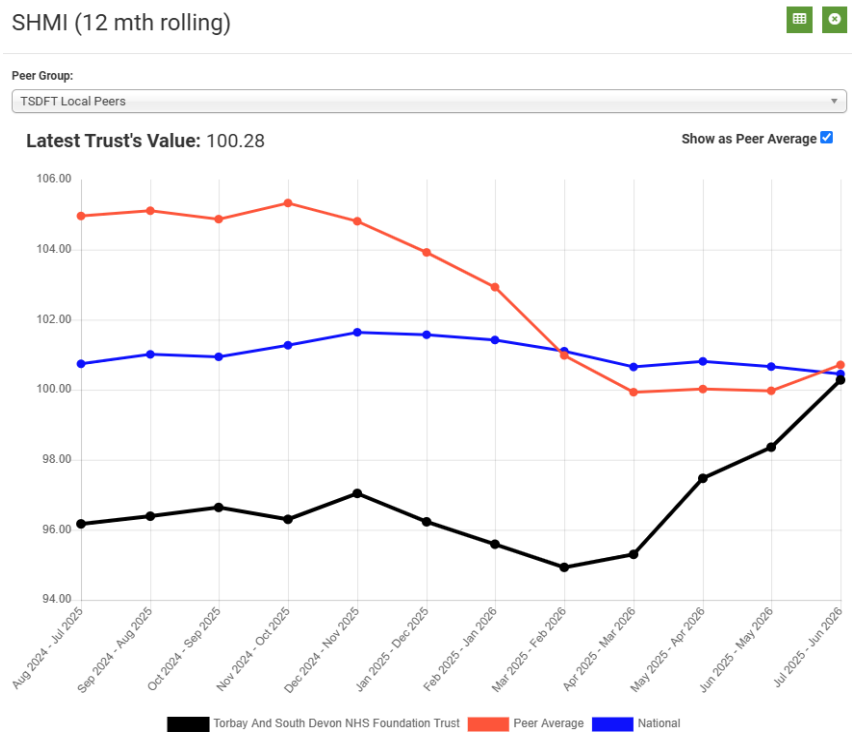
- Patient safety incidents associated with Corridor Care are monitored: 9 incidents were reported in September, none with moderate or severe level of harm and one with a severity of death, as reported above
- 43 Discharge & Transfer incidents were reported during September 2026. One 'discharge planning failure' incident was reported as moderate harm and is being reviewed. For PSR
- Two never events have been declared in September – both low harm. One wrong site surgery and one retained foreign object

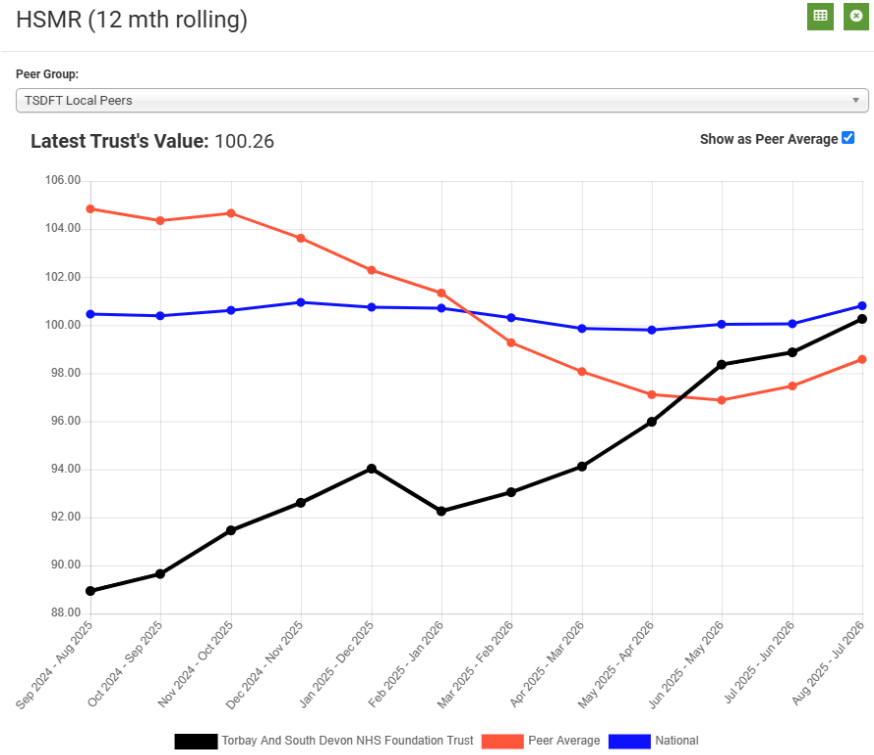
Quality and Safety exception reports – Mortality benchmarking

In September, the Trust implemented the benchmarking tool HED (Healthcare Evaluation Data) being a tool to support benchmarking against mortality, patient safety and operational efficiencies.

Headline mortality data will now be provided from HED and will show both the (HSMR) Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator (SHMI).

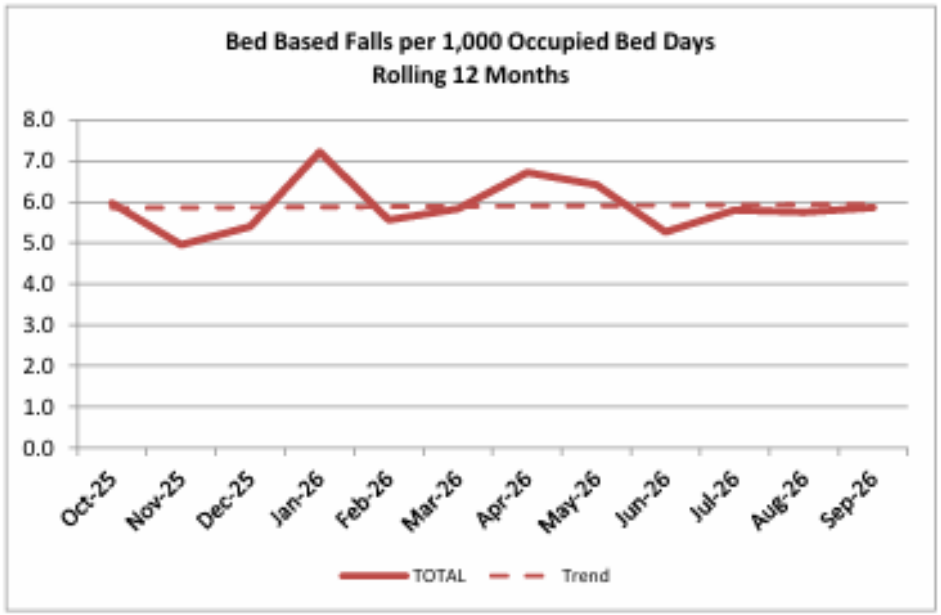
The latest Data below shows that at Trust level these metrics remain within expected levels. It is noted however that there is a trend toward National average in the recent data – full review of indicators at diagnostic group will be completed and reviewed through the Mortality Surveillance Group (MSG).





Areas to note and escalate: MSG to continue to monitor

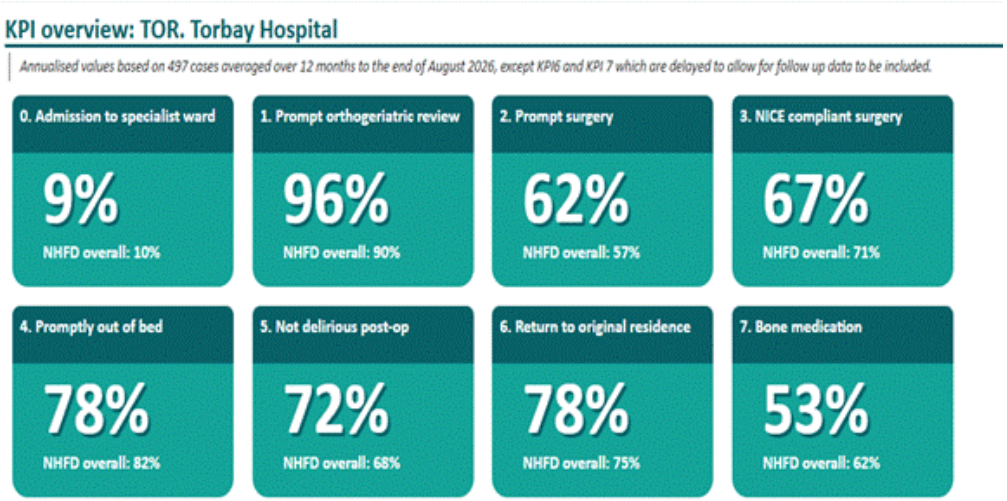
Quality and Safety exception reports – fractured neck of femur and falls



Falls

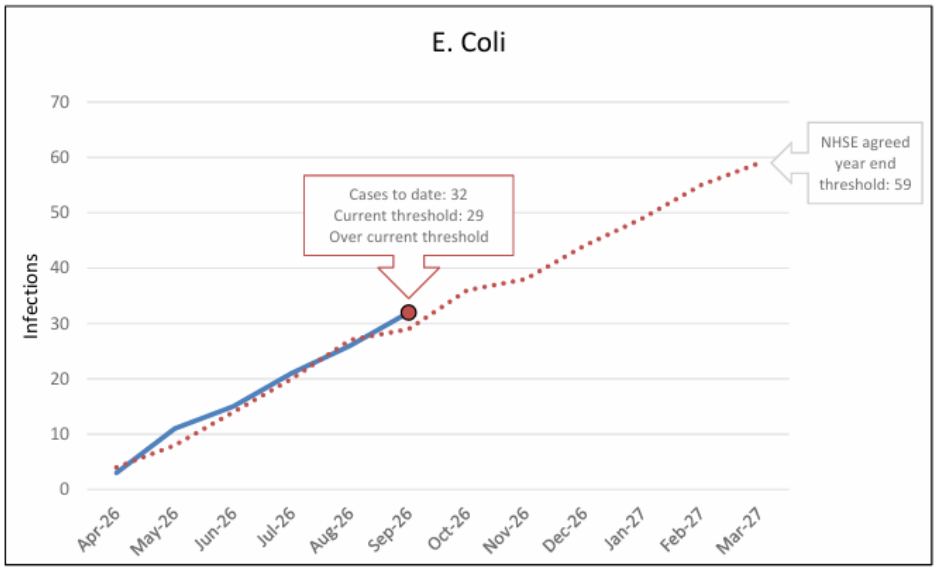
In the month of September, the Trust has remained static in regard to the number of falls that have occurred per 1000 bed days and in line with trust trajectory.

However there has been an increase in falls within the community hospitals due to specific patients. These have been reviewed in care group and learning applied to practice. Falls have decreased across the other care groups.



Fractured Neck of Femur (one month in arrears – Month 6 data not yet available on National Hip Fracture Database).
September 26 data
Total Hip fractures: 60
51 NOF's
9 other femur #'s
NOF: 1 delayed presentation (at home) average TTT was 33.2hrs

Quality and Safety exception report – Infection and Prevention Control



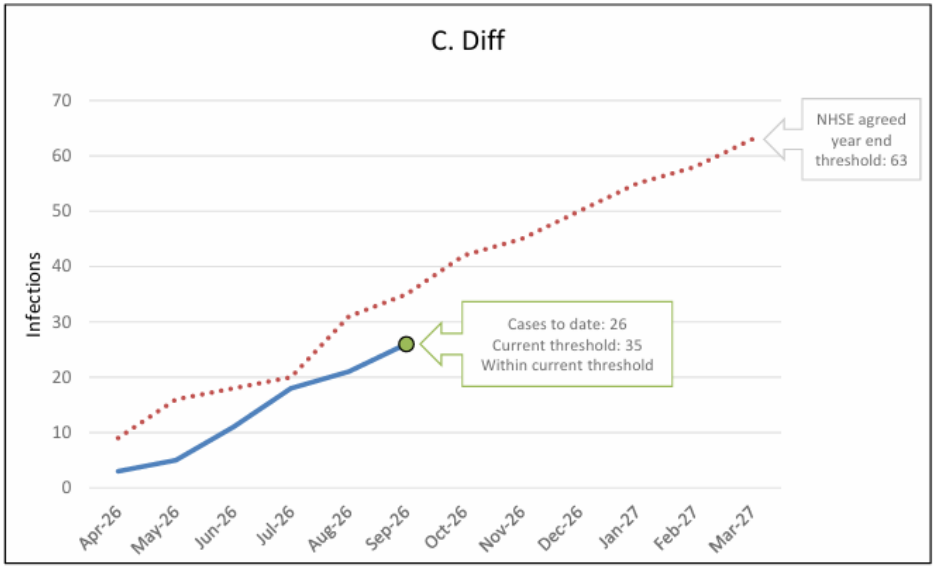
Escherichia coli (E.coli)

UKHSA require a 10% reduction in all Bloodborne Bacteraemia's (BBI's) in 2026. This has now been confirmed as an end of year threshold of 59 Escherichia coli (E.coli) BBI's.

To date there have been 32 E.coli infections detected, two above the predicted threshold of 30 for August 2026.

25 cases are classified as Community Onset Community Associated (COCA), which are not directly reflective of the quality of care provided by the Trust. 3 cases are Community Onset Healthcare Associated (COHA) with 2 identified as Hospital Onset Healthcare Associated (HOHA)

The IPC ADNPP has prioritised the E.coli Improvement plan providing targeted support across the ICO.



Clostridioides difficile (C.diff)

UKHSA require a 10% reduction in all Bloodborne Bacteraemia's (BBI's) in 2026. This has now been confirmed as an end of year threshold of 63 Clostridioides difficile (C.diff) BBI's.

To date there have been 26 C.diff BBI's which is below the agreed threshold of 35 for September 2026.

4 cases are classified as Community Onset Community Associated (COCA), which are not directly reflective of the quality of care provided by the Trust. 2 cases are Community Onset Healthcare Associated (COHA) with 3 identified as Hospital Onset Healthcare Associated (HOHA) and 3 listed as Community Onset Indeterminate Associated (COIA)

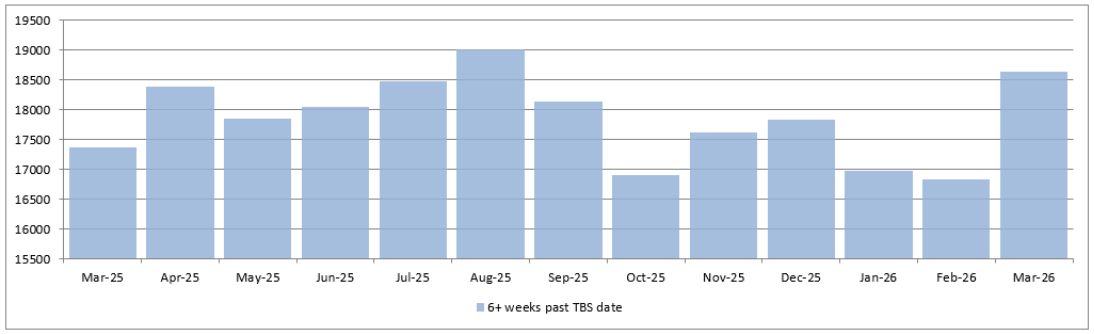
The IPC ADNPP has prioritised the C.diff Improvement plan providing targeted support across the ICO. And a weekly C.diff Multi-disciplinary team review for all in-patients

Quality and Safety exception reports Tissue Viability Service.

Torbay and South Devon NHS Foundation Trust

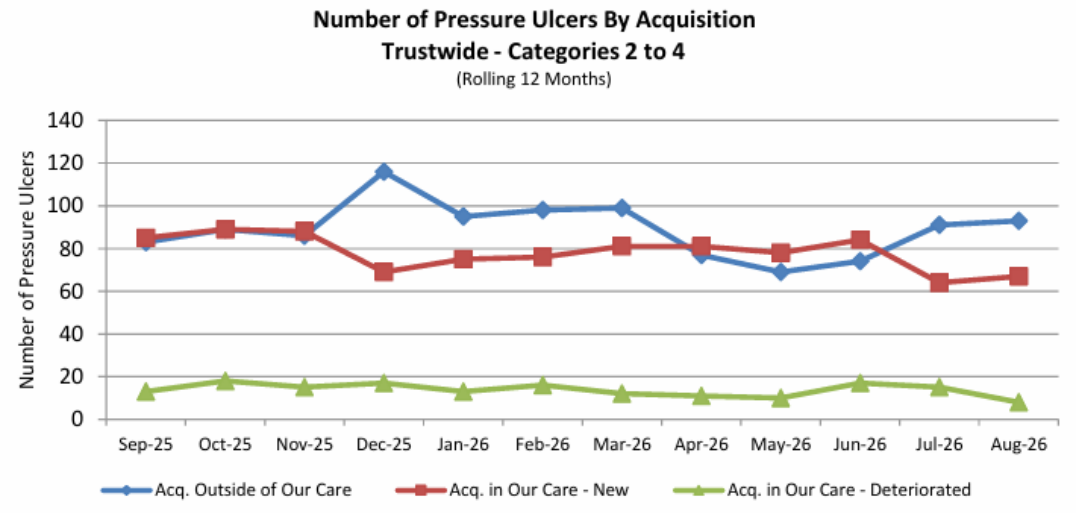
Follow ups 6 weeks past to be seen by date

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
6+ weeks past TBS date	17361	18380	17843	18040	18486	19016	18135	16900	17610	17827	16967	16835	18638



Follow-ups past 6 weeks to be seen

Due to the launch of EPIC, no data currently available.



Pressure Ulcer (PU) Categories 2 – 4

An increase of patients admitted into our care, with a PU, from 91 in July to 93 August.

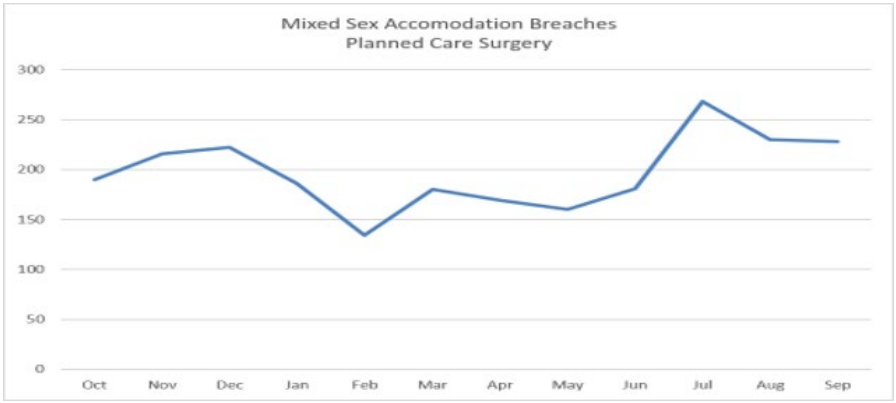
Patients with PU's, acquired in our care, has a slight increase in August from 64 in July to 67.

PU's deteriorated in Trust care has dropped from 15 in July to 8 in August.

Slight increase may be partially mitigated due to the hot weather across July and August.

The Tissue Viability Service continue to deliver Pressure Ulcer Prevention and Purpose T PURA training across the ICO. Through monthly PUP meeting themes are identified and action plans developed to address any issues identified from a local and trust perspective.

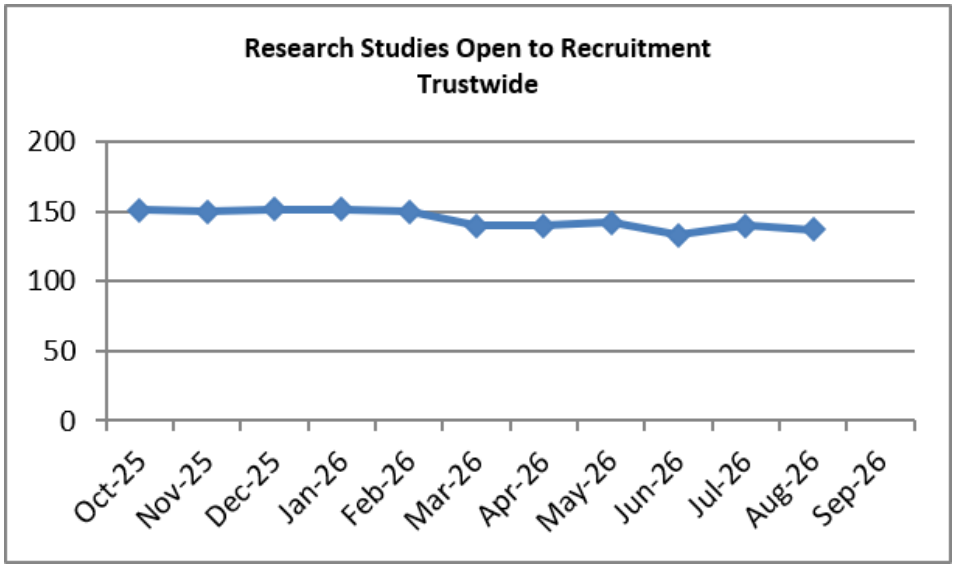
Quality and Safety exception report – Mixed Sex Accommodation



Mixed Sex Accommodation

All reported breaches related to mixed-sex accommodation on the Surgical Receiving Unit (SRU) those delayed & without transfer to an inpatient ward within four hours of a decision to admit.

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

Torbay and South Devon NHS Foundation Trust

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	Aug-26	Sep-26
Number of patients (N)		**50**	**58**	**53**	**57**	**44**	**51**	**56**	**40**	**61**	**48**	**49**	**56**	**55**	**45**	**39**
% 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%	31.60%	39.10%	55%
% 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%	43.60%	33.30%	55.30%
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	04:30	05:59	03:10
% 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%	72.70%	67.40%	74.4
% 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%	24.00%	16.70%	26.70%
% (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)	3.5% (2)	13% (5)	17.5% (6)
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	02:35	01:18	01:02

N**B: September data incomplete as 5 patients not yet discharged; performance metrics will change**

SOP giving protection of three stroke beds at all times came into force for 6-week test of change on 1st October. Indications are positive in October so far.

National results have been published for April – June 2026. Sadly, we remain an E but have also dropped from a D to an E for Domain 1 – Hyperacute Assessment. As can be seen from the table above and previous reports we have struggled with several of our key indicators over those months. Data for September is looking more positive – although these figures will change as some patients are still not included in the data.

- 55% of patients currently on SSNAP were scanned within 20 minutes; this is positive as we progress towards our ambition of implementing PITSTOP (where SWASFT will wait for 30 minutes to take patients direct to Derriford for thrombectomy)
- 55.3% of patients currently on SSSNAP got to the stroke unit in 4hrs. If sustained this will be the highest score that we have recorded since pre-January 2023.
- 17.5% of patients currently on SSNAP were thrombolysed.

DIDO work (reviewing the door-in-door-out process for patients arriving at ED who subsequently go for thrombectomy is complete. A report is pending.

Stroke Actions:

- Samuel tool (thrombolysis predictor) to review a sample of non-thrombolysed – remains outstanding (Samuel data has now been refreshed with data April 1st 2021-March 31st 2024)
- Evaluate use of hyper-acute SOP with analysis of breaches as they happen.
- Pre-hospital triage work progressing – aiming to begin trial in November.
- Discussions being held re: thrombolysis happening within radiology footprint

Other work

Work has started across the region to deliver an out of hours reperfusion rota by April 2028. Early discussions indicate this will be just Devon & Cornwall & just extended window thrombolysis as a thrombectomy process already exists. In interim TSDFT are still exploring joining the West of England rota

Report has been received following visit on 23rd July from Regional Medical Director. Actions are being reviewed but most are already in discussion or development.

Risks No additional capacity to undertake improvement work

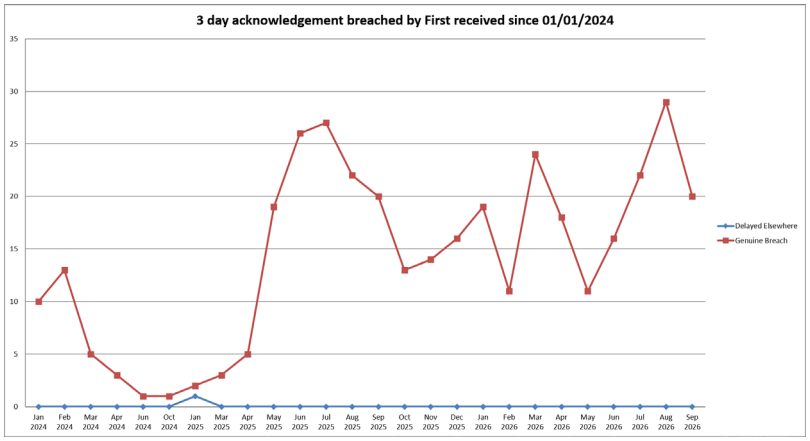
Quality and Safety exception report – Feedback and engagement

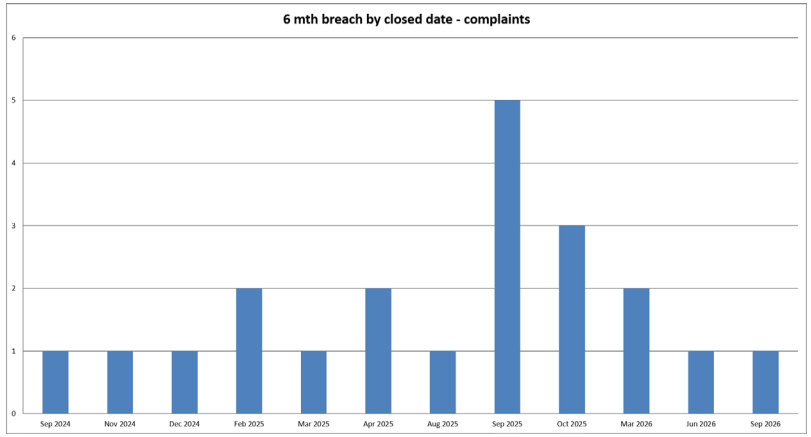
Torbay and South Devon NHS Foundation Trust

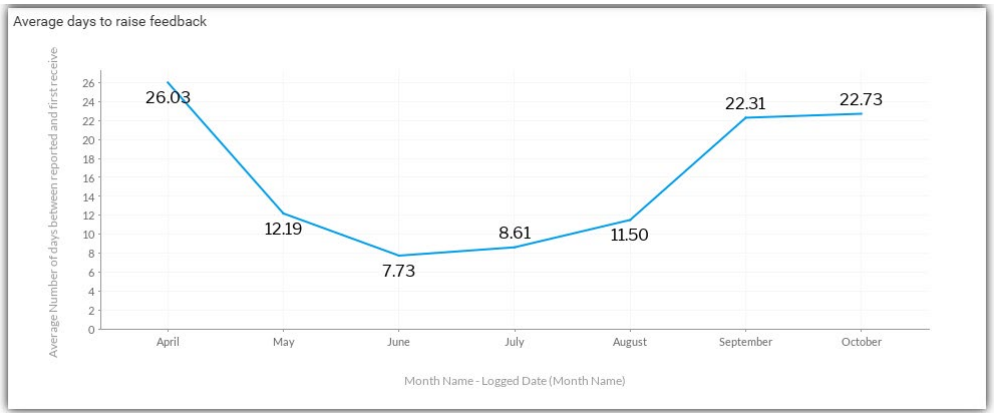
Complaint Metrics

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)







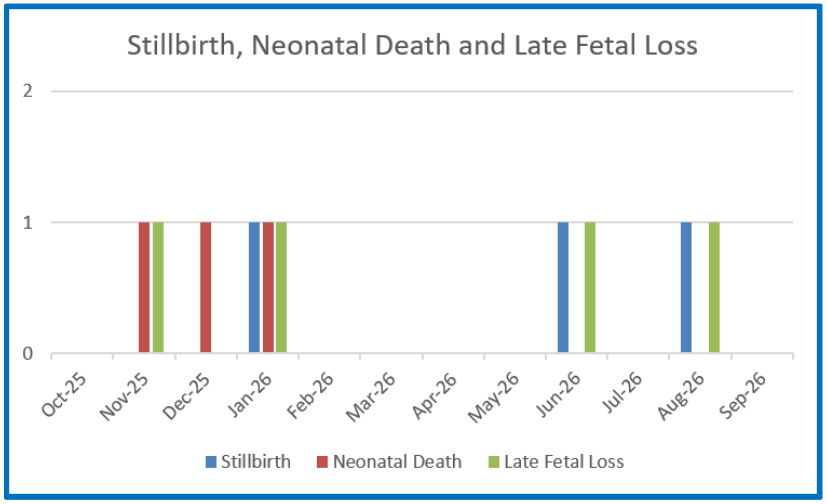
Complaint acknowledgement breaches remain above target and have increased since June, peaking during recent months. Improvement plan in development.

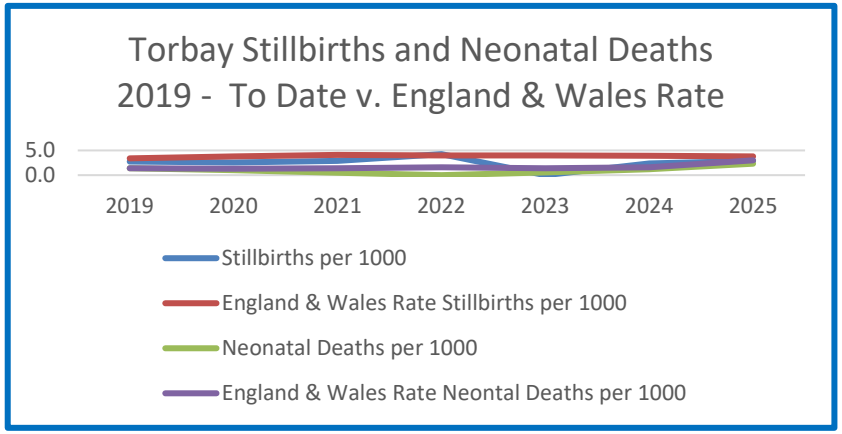
Six-month complaint closure breaches continue to occur, although volumes remain relatively low and variable.

Average time taken to log feedback has risen steadily, highlighting a need to strengthen timeliness across complaint processing and oversight. Online complaint and PALs forms now live and available.

A drive on collecting FFT responses has taken place. A submission to NHSE made for September 2026 data.

Quality and Safety- Perinatal Clinical Quality Surveillance October 2026 (September 2026 data) Maternity





Mortality:

- **November 2025** - 1 x Late Fetal Loss -(LFL) 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 diagnostic test.
- **January 2026** – 1 x Stillbirth at 28+2, 1 x NND 29+1 baby died in a tertiary unit following delivery in Torbay due to infection, 1 x Late fetal loss. 21 weeks died following amnio. Chromosomal anomaly detected,
- **June 2026** – 1 x Stillbirth at 27/40,. 1 x LFL at 23+3 weeks gestation.
- **August 2026** – 1 x Stillbirth at 38+1, 1 x LFL at 21 weeks.

Incidents moderate and above = 8
Incidents moderate and above = 8

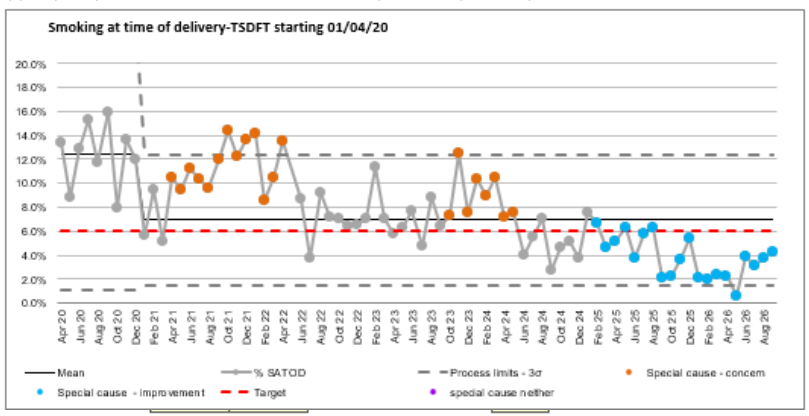
- 1 Severe for Missed Anti D
- 1 Mod for Sepsis
- 3 Mods for PPH
- 2 x Mods for 3rd Degree Tears- all cases reviewed by pelvic health midwife
- 1 x Mod Preterm Delivery <28 Weeks in Level 1 Unit

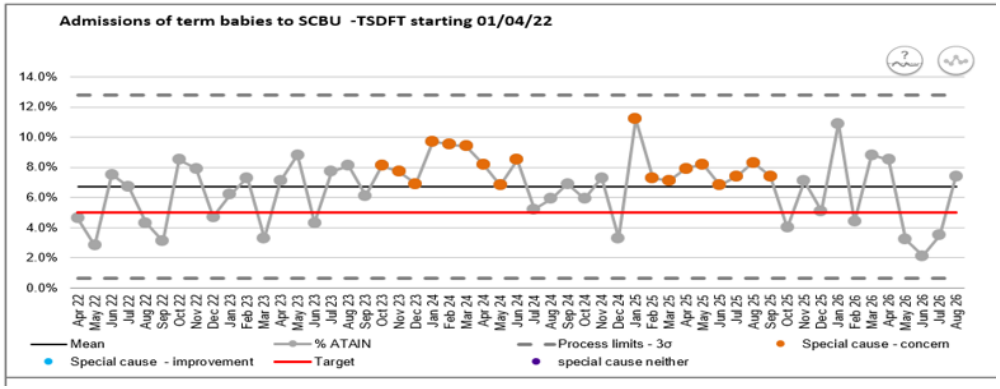
MNSI – None
CQC – None
Coroner referral – None

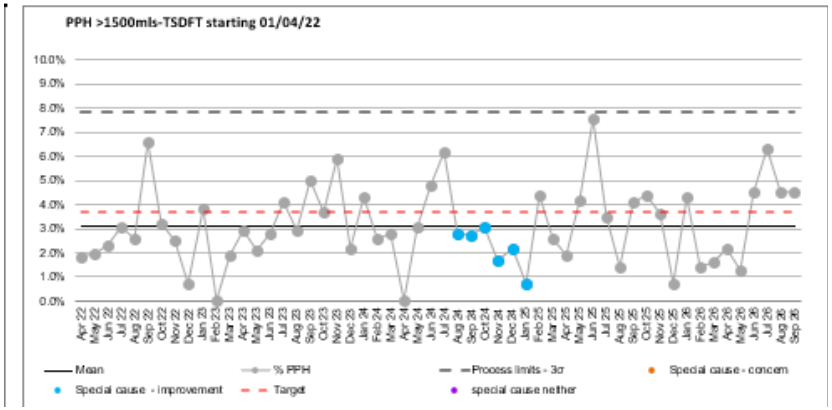
Quality and Safety exception report – Metrics relating to the provision of quality maternity care

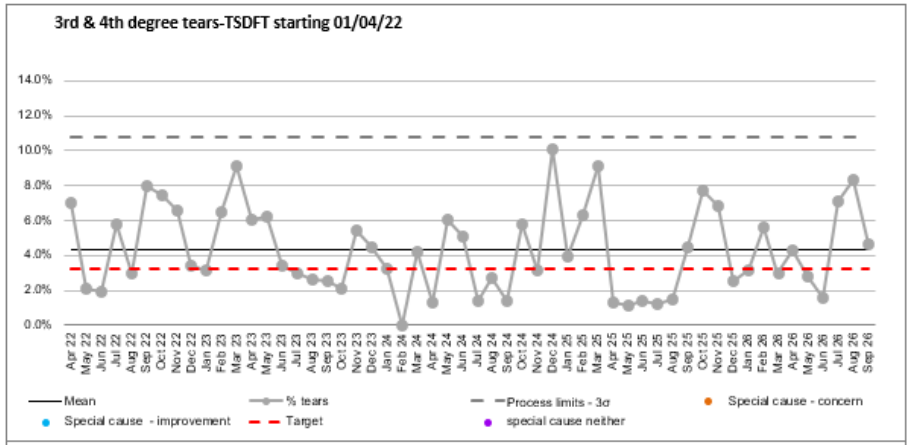
Torbay and South Devon NHS Foundation Trust

- 168 Births in September 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 of 4.2% is checked for accuracy by smoking cessation team. Quarterly total of 3.66%.
- Significant decrease in the number of 3rd/4th degree from 8.3% in August to 4.6% in September. Quarterly average 6.6%; 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 decrease in incidence of PPH>1500mls from 4.5% August to 3.0% in September . Thematic review completed and shared at the Trust Patient Safety Incident Group (PSIRG). Action plan being developed.
- Increase in Term baby admissions to SCBU in August to 7.4%. Quarterly rate **4.33**%; National target is 5% or less. Data obtained from Badgernet. Due to the rise in rate, confirmation being sought from team around accuracy of data quality due to interface of Badgernet and Epic.





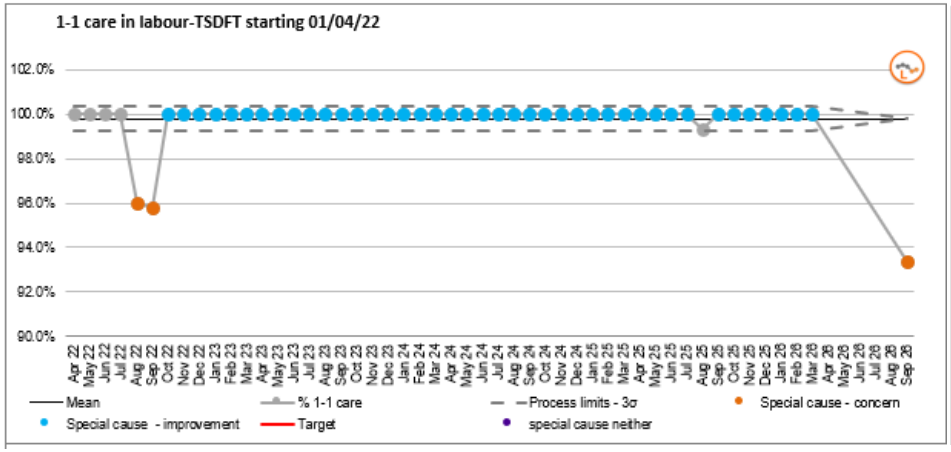


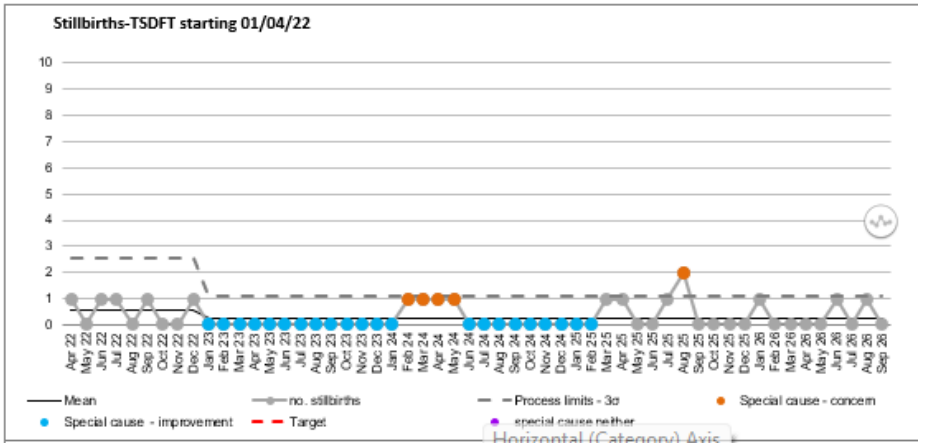


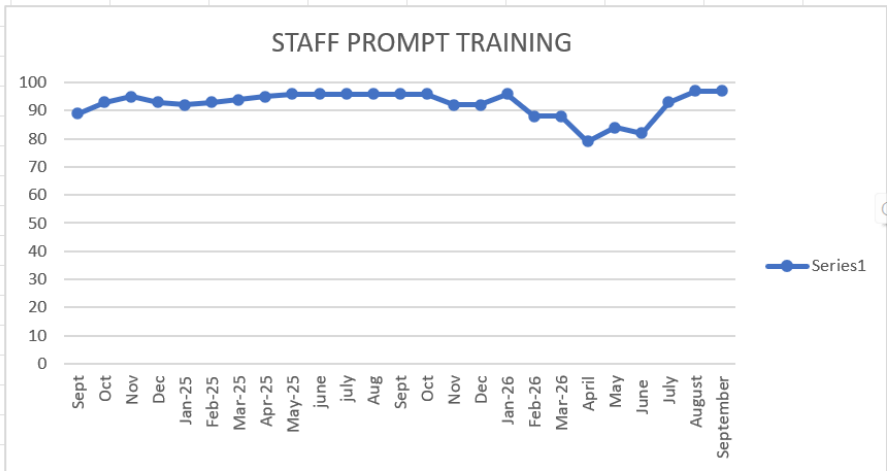
Quality and Safety exception report – Metrics relating to the provision of quality maternity care September 2026

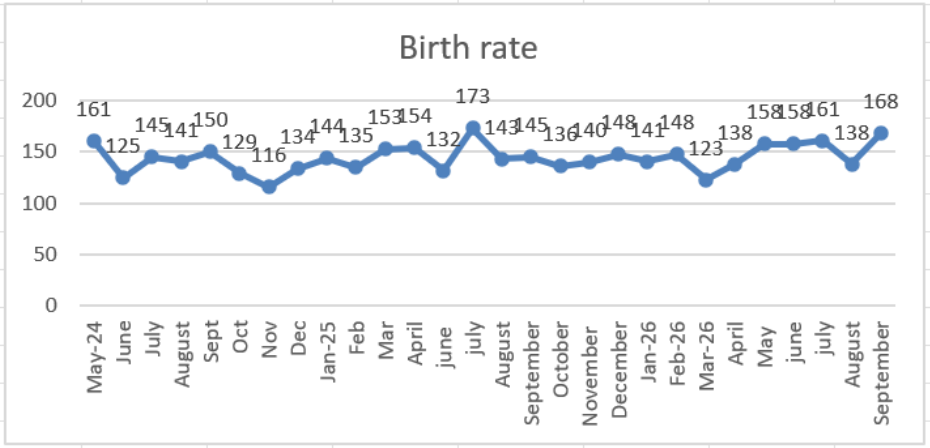
Torbay and South Devon NHS Foundation Trust

One to one care has now been added to Epic. The drop in compliance relates to the change in data collection rather than a drop in performance. This metric is no longer mandated as reportable too.









Quality and Safety – Safer Staffing – Dashboard and CHPPD data- September 2026

Torbay and South Devon NHS Foundation Trust

Inpatient Wards (All)

Staffing Metrics					
Beds			Establ. Beds		518
			Bed Occ.		93.5%
Staffing Fill Rates	Days		RN / Midwives		89.7%
			Care Staff		90.9%
	Nights		RN / Midwives		94.6%
			Care Staff		108.1%
Actual Staffing Split	Days		% RN / Midwives Hours		54.9%
			% Care Staff Hours		45.1%
	Nights		% RN / Midwives Hours		53.3%
			% Care Staff Hours		46.7%
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	Planned		2.5
			Actual		2.2
		Care Staff	Planned		2.0
			Actual		1.8
		Overall Day	Planned		4.4
			Actual		4.0
	Nights	RN / Midwives	Planned		1.9
			Actual		1.8
		Care Staff	Planned		1.4
			Actual		1.6
		Overall Night	Planned		3.3
			Actual		3.3
HR Metrics			Sickness Rate	(Jul-26)	6.1%
			Turnover Rate	(Aug-26)	11.0%
			Vacancy Rate	(Aug-26)	8.2%
Temporary Staffing			Prop. Bank Hours	(Aug-26)	5.5%
			Prop. Agency Hours	(Aug-26)	0.1%
Patient Sensitive Indicators					
Safety	Red Flags Raised		EToC Red Flags		17
			All Red Flags		58
	Mod. Harm Incs and Above				14
	PUs G2+ Acq. in Our Care				0
	Falls		No Harm		40
			Harm		55
	Medicine Errors				23
	% Obs Taken on Time			(Mar-26)	91.5%
Feedback	Patient Complaints				4
	FFT		% Positive Resp.	(Jul-25)	-
			Number of Resp.	(Jul-25)	-

Emergency Care (ED Only)

Staffing Metrics				
Number of Attendances				7,380
Staffing Fill Rates	Days	RN / Midwives	(Aug-26)	97.0%
		Care Staff	(Aug-26)	85.0%
	Nights	RN / Midwives	(Aug-26)	91.5%
		Care Staff	(Aug-26)	64.1%
Actual Staffing Split	Days	% RN / Midwives Hours	(Aug-26)	65.1%
		% Care Staff Hours	(Aug-26)	34.9%
	Nights	% RN / Midwives Hours	(Aug-26)	70.0%
		% Care Staff Hours	(Aug-26)	30.0%
HR Metrics		Sickness Rate	(Jul-26)	8.4%
		Turnover Rate	(Aug-26)	13.4%
		Vacancy Rate	(Aug-26)	23.1%
Temporary Staffing		Prop. Bank Hours	(Aug-26)	5.3%
		Prop. Bank Hours	(Aug-26)	0.0%
Patient Sensitive Indicators				
Number of Unplanned Reattendances				960
Service Delivery Times		% Waiting > 4 Hrs		40.4%
		% Waiting > 12 Hrs		12.2%
		Avg. Triage Time (mins)	(Aug-26)	23
		Amb. Handovers < 30 mins		41.4%
Safety		All Red Flags		0
		Mod. Harm Incs and Above		4
		Medicine Errors		6
		PUs G2+ Acquired in Our Care		0
	Falls	No Harm		1
		Harm		2
	Sepsis	% Overall Sepsis 6		100.0%
		% Antibiotics within 1 Hour		100.0%
Feedback		Patient Complaints		4
	FFT	% Positive Resp.	(Jul-25)	
		Number of Resp.	(Jul-25)	

Quality and Safety – Safer Staffing – Dashboard September 2026

Torbay and South Devon NHS Foundation Trust

September 2026 inpatient staffing fill rates remained broadly within tolerance overall, although the daytime registered nursing position deteriorated. Registered nurse/midwife fill reduced from 90.8% in August to 89.7% in September, moving from green to amber, while night fill improved from 93.9% to 94.6% and remained green. Care staff fill rate reduced from 95.4% to 90.9% during the day and from 110.8% to 108.1% at night, with both remaining green. The daytime registered nurse/midwife position continues to require monitoring through twice-daily staffing meetings, SafeCare oversight and senior nursing review. Bed occupancy increased marginally from 93.4% in August to 93.5% in September and remained red against the dashboard threshold, demonstrating continued pressure across inpatient services. Operational focus remains on patient flow, timely discharge planning, effective use of the Discharge Lounge, escalation capacity and deployment of staffing according to acuity, dependency and risk. Inpatient CHPPD reduced slightly but remained broadly aligned to planned staffing. Overall actual CHPPD reduced from 4.2 to 4.0 during the day and from 3.4 to 3.3 at night. Actual registered nurse/midwife CHPPD remained 2.2 during the day and 1.8 at night, while actual care staff CHPPD reduced from 1.9 to 1.8 during the day and remained 1.6 at night. The main variance continued to be within daytime registered nurse/midwife hours.

Workforce indicators showed a mixed position. Inpatient sickness increased from 5.2% in August to 6.1% in September and remained red-rated. Turnover increased from 10.7% to 11.0%, while vacancy increased marginally from 8.1% to 8.2%, with both remaining green. Bank hours reduced from 6.2% to 5.5%, while agency hours remained very low at approximately 0.14%. Continued senior nursing and workforce governance oversight is required, particularly in relation to sickness, staffing fill and temporary staffing demand. Patient-sensitive indicators demonstrated a mixed position. All red flags increased from 25 in August to 58 in September, while EToC red flags increased from 3 to 17. Moderate harm incidents and above remained unchanged at 14, and no grade 2+ pressure ulcers acquired in our care were reported. No-harm falls reduced from 47 to 40, but falls with harm increased from 47 to 55. Medicine errors reduced from 28 to 23, observations completed on time remained stable at 91.5%, and patient complaints increased from 2 to 4. FFT positive-response and response-volume data remained unavailable. The increase in red flags, EToC red flags and falls with harm requires focused triangulation with staffing, acuity, dependency, occupancy and workforce availability.

Within the Emergency Department (ED), the September dashboard continues to report the latest staffing fill data as August 2026. Registered nurse fill was 97.0% during the day and 91.5% at night, while care staff fill was 85.0% during the day and 64.1% at night. The latter remained a significant overnight staffing concern. The latest workforce data showed sickness at 8.4% for July 2026, with turnover at 13.4%, vacancy at 23.1%, bank use at 5.3% and agency use at 0.0% for August 2026. The continued care staff shortfall, sickness and vacancy position requires focused workforce oversight, but the different reporting periods should be recognised when triangulating these indicators.
ED attendances reduced slightly from 7,403 in August to 7,380 in September, while unplanned reattendances reduced from 989 to 960. The proportion waiting over four hours improved from 51.3% to 40.4% and waits over 12 hours reduced from 13.5% to 12.2%. Average triage time improved from 24 to 23 minutes. The latest ambulance handover result remained 41.4%, but this measure is labelled August 2026 in the September workbook. Despite improvements in the other flow measures, the position continued to demonstrate significant operational and patient-flow pressure. ED safety indicators showed an improving but mixed position. Moderate harm incidents and above reduced from 5 to 4, medicine errors reduced from 8 to 6, and no-harm falls reduced from 2 to 1, while falls with harm remained at 2. Sepsis 6 compliance improved from 92% to 100%, while antibiotics administered within one hour remained at 100%.

Overall, the September safer staffing position demonstrates continued organisational oversight of staffing risk across inpatient and emergency services.

Community and Social Care Indicators - Summary of key metrics

Torbay and South Devon NHS Foundation Trust

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

Opiate users - % successful completions of treatment (quarterly - 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community 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%)		

Community and Social Care Indicators – Community Waiting List – greater than 52 week wait

Torbay and South Devon NHS Foundation Trust

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. Due to the introduction of the new electronic patient record (Epic) implementation, validation and data quality checks are on-going.

In September, 53 people are reported as waiting over 52 weeks for an appointment with 17 people being under Nursing and Therapy Support: Stroke.
The Trust has met the target of 78% of people being seen within 18 weeks with performance at 86%; this remains stable from August performance.

Community Waiting Times (snapshot on 30th Sept 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	38	0	0	0	38	100%
(A): Musculoskeletal service	2,739	197	2	0	2938	93%
(A): Nursing and Therapy support LTCs: Diabetes	42	9	0	0	51	82%
(A): Nursing and Therapy support LTCs: Falls	169	13	0	0	182	93%
(A): Nursing and Therapy support LTCs: Lymphoedema	55	1	0	0	56	98%
(A): Nursing and Therapy support LTCs: Stroke	201	53	17	0	271	74%
(A): Podiatry and podiatric surgery	1017	143	0	0	1160	88%
(A): Rehabilitation services	458	71	8	0	537	85%
(A): Therapy interventions: Dietetics	277	56	10	0	343	81%
(A): Therapy interventions: Orthotics	1	4	0	0	5	20%
(A): Therapy interventions: Speech and language	209	49	5	0	263	79%
(A): Urgent Community Response/Rapid Response team	4	0	0	0	4	100%
(A): Weight Management and obesity services	51	102	11	0	164	31%
(CYP): Community paediatric service	199	159	0	0	358	56%
(A): Therapy interventions: Physiotherapy	5	5	0	0	10	50%
Total	**5815**	**862**	**53**	**0**	**6730**	**86%**

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 5 2026/27

Following migration to LAS in late August, several KPIs have been affected by revised data capture methodologies. Waiting list and overdue review data in particular should be interpreted with caution until new baselines have been established.

Waiting list performance remains mixed across services. STTT and CCT waiting lists have continued to reduce. STTT reduced from 162 to 113 and CCT from 78 to 57, with both services returning to below the pre-set UCL during M06. OPMH (70 to 55), Occupational Therapy (202 to 100) and Transitions (34 to 29) also showed improvements, albeit with certain migration related DQ issues a factor. However, AMHSC waiting list increased (25 to 36) and IHF waiting list increased substantially from 74 to 121. The IHF process remains outside LAS and therefore reflects a continued picture of increases outside any migration related impacts.

Review performance is another area presently impacted by migration. The recorded number of overdue reviews reduced from 1,530 to 1,217, although the proportion of reviews in date also reduced slightly from 53.0% to 52.7% and remains below the 60% target. Changes to review capture methodology and denominators are likely influencing the review measures.

Performance relating to Out of Area Placement reviews continues to improve. The number of overdue reviews reduced from 11 to 7 and the proportion of reviews in date increased further to 92.6%, well above the 60% target.

The number of people with an active Direct Payment remains stable at 368, in line with the 12-month average. Whilst migration appears to have had little impact on Direct Payment users, increases have been recorded in the number active held within the AMHSC and OPMH teams.

Interim Health Funding remains an area of pressure based on the waiting list indicators. The waiting list has increased by 63% from mid August to 121. Median wait has increased to 40 days and maximum wait to 257 days, both the highest figures recorded in the reporting period.

Cost and volume has seen notable increases since migration to ContrOcc. This is in part attributable to a substantial piece of work completed by AST to process outstanding contracts prior to migration, creating a one-off increase in activity. Increases have been primarily seen in the Home Care and Supported Living service areas.

Adult Social Care – Principle KPIs – Month 5 2026/27

NHS Torbay and South Devon NHS Foundation Trust

KPI	M05 mid	M06 end	Direction	12M Ave	M05 Comment
DOMAIN 1: Working With People					
Waiting Lists					
HSCC Outstanding Enquiries	415	-		-	M06 data unavailable due to LAS migration DQ
Front End Waiting List	162	113	▼	173	
Complex Care Waiting List	78	57	▼	80	
AMHSC Waiting List	25	36	▲	23	UCL Breach
OPMH Waiting List	70	55	▼	52	UCL Breach
Torquay OT Waiting List	69	100	▼	110	Significant under reporting likely M06
P&B OT Waiting List	131				
FAB Waiting List	100	-		-	M06 data unavailable due to LAS migration DQ
Transitions Waiting List	34	29	▼	39	
IHF Waiting List	74	121	▲	71	UCL Breach
DoLs					
Non Authorised DoLS	509	-		-	M06 data unavailable due to LAS migration DQ
Dols applications received	47	-		-	M06 data unavailable due to LAS migration DQ
Dols applications allocated	30	-		-	M06 data unavailable due to LAS migration DQ
Dols applications authorised	38	-		-	M06 data unavailable due to LAS migration DQ
Support Plans					
Proportion of Support Plans sent	-	-		-	M06 data unavailable due to LAS migration DQ
Direct Payments					
Direct Payment Users	370	368	▼	369	Below Target
ASCOF Measure 3D2A (%)	18.4	18.5	▲	18.2	Below Target
ASCOF Measures					
ASCOF Measure 2A	94.7	94	▼	92.4%	
ASCOF Measure 2B	22.1	20.9	▼	22.9	Above Target
ASCOF Measure 2C	651.3	645.0	▼	711.1	Above Target
Reviews					
Overdue Reviews (All)	1,530	1,217	▼	1,364	
Proportion Not Overdue (All)	53.0%	52.7%	▼	55.7%	Below Target
Overdue Reviews (OOA Placements)	11	7	▼	23	
Proportion Not Overdue (OOA Placements)	88.2%	92.6%	▲	72.2%	
Ethnicity					
% ethnicity recorded	87.7%	88.2%	▲	86.7%	Below Target

Adult Social Care – Principle KPIs continued

NHS Torbay and South Devon NHS Foundation Trust

KPI	M05 mid	M06 end	Direction	12M Ave	M05 Comment
DOMAIN 2: Providing Support					
Cost & Volume					
Person Count (All)	2,770	2,808	▲		
Gross Weekly Cost (All)	£2,061,006	£2,075,677	▲		
Person Count (PD)	1,383	1,395	▲		
Gross Weekly Cost (PD)	£832,119	£842,201	▲		
Person Count (M&C)	220	220	↔		
Gross Weekly Cost (M&C)	£220,325	£220,314	▼		
Person Count (LD)	606	611	▼		
Gross Weekly Cost (LD)	£643,080	£640,939	▼		
Person Count (MH)	502	518	▲		
Gross Weekly Cost (MH)	£343,552	£344,939	▲		
Referrals (In-month)					
Customer Service Referrals	2,246	-		-	M06 data unavailable due to LAS migration DQ
HSCC Referrals	1,534	-		-	M06 data unavailable due to LAS migration DQ
Front End Referrals	186	-		-	M06 data unavailable due to LAS migration DQ
Complex Care Referrals	18	-		-	M06 data unavailable due to LAS migration DQ
Mental Health Referrals	46	-		-	M06 data unavailable due to LAS migration DQ
Hospital Discharge					
Total Complex Discharge (P1-P3)	141	168	▲	143	
P1 Discharges	88	99	▲	90	
P2 Discharges	39	53	▲	42	
P3 Discharges	14	16	▲	11	
Rehab / Recov Utilisation					
Jack Sears	67%	86%	▲	64%	
Hill House	96%	78%	▼	71%	
DOMAIN 3: Ensuring Safety In The System					
Safeguarding					
Safeguarding Referrals Open (SPOC)	4	27	▲	34	
Safeguarding Referrals Open (Non SPOC)	94	40	▼	95	
S.42 over 90 days	-	51	-	-	M05 figure unavailable due to LAS switch DQ
DOMAIN 4: Leadership					
Appraisals					
ASC Overall	54.6%		▼	63.1%	Awaiting M06 data
Training Compliance					
ASC Overall	83.7%		▲	83.9%	Awaiting M06 data

Workforce – Executive Summary – Month 6

Torbay and South Devon NHS Foundation Trust

Month 6 presents a mixed workforce position. Total workforce utilisation, including substantive, bank and agency staffing, was 6,364 WTE against a budgeted establishment of 6,344 WTE. However, the worked workforce remained 50 WTE below establishment at 6,295 WTE, while substantive contracted workforce reduced by 14 WTE to 5,987 WTE, remaining 63 WTE below the substantive plan of 6,050 WTE.

The workforce financial position improved in-month, with expenditure £67.5k below budget, reducing the cumulative year-to-date overspend to £405.4k. Substantive pay remained favourable, with a year-to-date underspend of £1.94m. However, this continues to be offset by temporary staffing pressures. Bank expenditure was £281.7k above budget in-month and £1.84m above budget year to date, while agency expenditure was £142.4k above budget in-month and £507.9k above budget year to date.

Sickness absence increased to 5.67%, compared with 5.35% in August, and remains above both the Trust target of 4.80% and the latest available national NHS benchmark of 5.0%. Nationally, almost a third of sickness absence relates to anxiety, stress, depression and other psychiatric illness. The Trust's sickness deep dive similarly identifies long-term absence as the principal challenge, accounting for 67.5% of absence and 475,308 hours lost, with mental health and musculoskeletal conditions representing the main areas for targeted intervention. The emerging improvement programme will focus on prevention, earlier intervention, management capability and integrated support, with the full improvement plan to be presented next month.

Appraisal compliance remains below the Trust target of 90%, with AfC compliance improving to 76.33% and Medical compliance at 77.48%. While AfC compliance is above the available local benchmark of 70.30%, appraisal remains the Trust's lowest-scoring area in the 2025 National Staff Survey (4.33). Survey results indicate a workforce experience that remains under pressure, with a response rate of 35.55%, below the national average, and morale remaining below South West and national benchmarks despite a small local improvement.
However, the Trust's Q1 2026/27 National Oversight Framework People score improved from quartile 3 to quartile 2, placing it within the second-highest quartile of acute providers, reflecting positive performance across nationally assessed workforce measures including sickness absence, staff engagement and education and training satisfaction.

Mandatory training compliance improved to 87.01% and remains above the 85% target. However, Manual Handling, Information Governance and Infection Control remain below the required threshold and continue to require targeted improvement.
Employee Relations case volumes remained broadly stable at 29 open formal cases. However, average completion time increased to 126 days, against the 60-day KPI, with manager-related factors accounting for 75% of recorded delays. Continued focus is required on timely case progression and management accountability.

Overall, Month 6 shows an improved in-month financial position and positive movement in turnover, mandatory training and AfC appraisal compliance. However, the Trust remains reliant on temporary staffing, while sickness absence, appraisal compliance and ER case duration continue to present significant challenges. Continued focus on substantive recruitment and retention, attendance improvement, workforce redesign, productivity and temporary staffing reduction will be critical to improving workforce sustainability and financial

Workforce Performance Summary - Month 6

NHS Torbay and South Devon NHS Foundation Trust

	Last Month (Aug 26)	Current Month (Sep 26)	Target	Change from last month	Performance against target	Local Benchmark comparisons
Sickness	5.35%	5.67%	<4.90%	↑		Devon 5.66% National 5%
Sickness Cost	£13.5m	£13.6m	£12.5m	↑		NA
Turnover (12-month rolling)	17.27%	16.11%	<12%	↓		11.90%
AfC Appraisal	75.15%	76.33%	>90%	↑		70.30%
Medical Staff Appraisal	77.70%	77.48%	>90%	↓		NA
Combined Mandatory Training	86.62%	87.01%	>85%	↑		84.60%
Infection Control	83.83%	83.83%	>85%	→		NA
Information Governance	81.04%	81.00%	>85%	↓		NA
Manual Handling	66.20%	67.68%	>85%	↑		NA
Safeguarding Children	85.31%	85.26%	>85%	→		NA
Safeguarding Adults	94.78%	95.18%	>85%	↑		NA
Understanding Sexual Misconduct Training	64.7%	70%	85%	↑		NA
Agency % of Budgeted Pay Bill	1.51%	1.49%	<1.05%	↓		NA
Bank % of Budgeted Pay Bill	5.87%	5.31%	<4.44%	↓		NA
Total Workforce Plan WTE	6419	6364	<6344	↓		NA
Substantive Workforce Plan WTE	6001	5987	<6050	↓		NA

Please note: WTE Targets are against Month 6 Plan

Workforce Position to Date

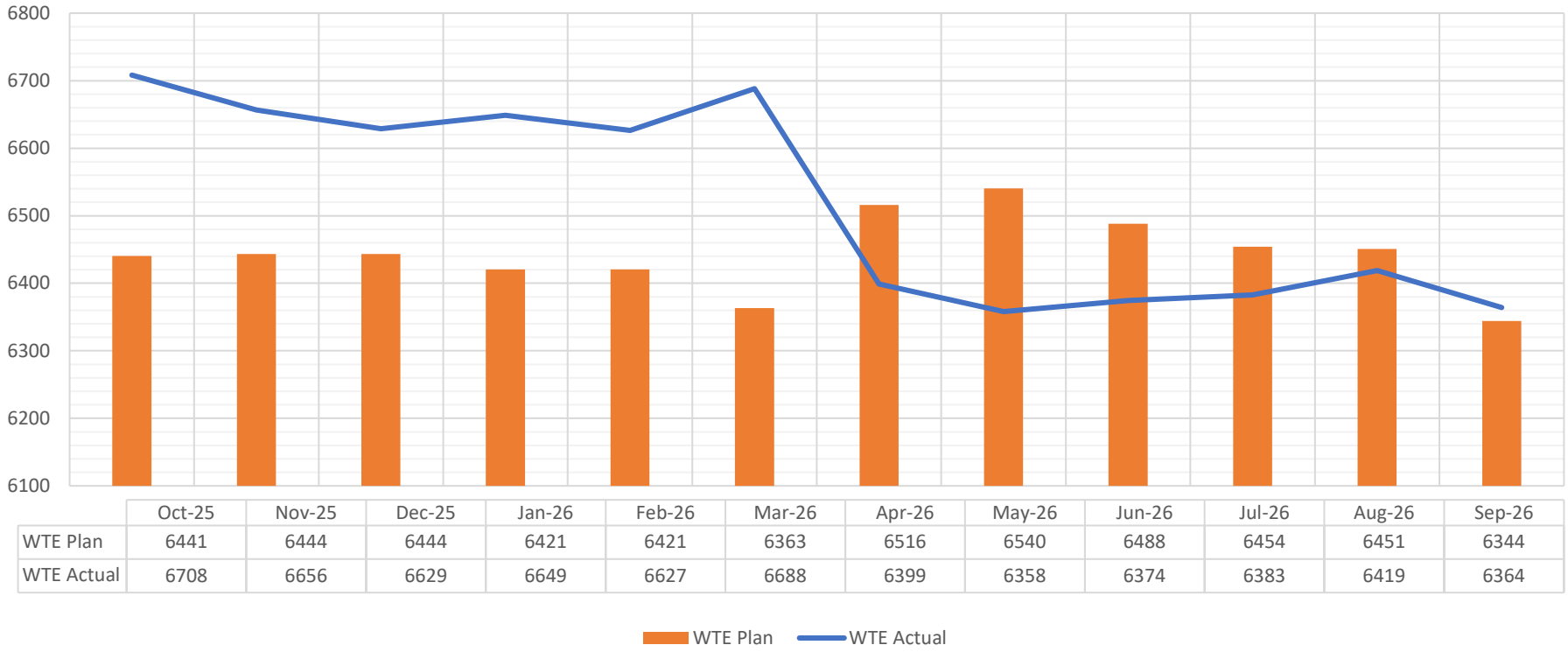
	WTE						£					
Month 6	M06 2026/27 Budget WTE	M06 2026/27 Contracted WTE	M06 2026/27 Worked WTE	WTE Worked Variance to Budget	M06 2026/27 Contracted + Bank + Agency	WTE Contracted variance to budget	M06 Budget £	M06 Actual £	£ Difference to Budget	YTD Budget £	YTD Actual £	YTD Variance £
Agency	36	0	53	17	53	17	£340,783	£483,186	£142,403	£2,061,511	£2,569,401	£507,890
Bank	259	0	324	65	324	65	£1,440,388	£1,722,133	£281,745	£8,704,599	£10,543,067	£1,838,468
Substantive	6050	5987	5918	-132	5987	-63	£30,652,646	£30,160,997	-£491,649	£181,861,485	£179,920,532	-£1,940,953
Grand Total	**6344**	**5987**	**6295**	**-49**	**6364**	**20**	**£32,433,817**	**£32,366,316**	**-£67,501**	**£192,627,595**	**£193,033,001**	**£405,406**

Workforce expenditure remains under close scrutiny at Month 6. Expenditure was £67.5k below budget for the month, reducing the year-to-date overspend to £405.4k. Total workforce utilisation, including substantive, bank and agency staffing, was 6,364 WTE against a budgeted establishment of 6,344 WTE, representing 20 WTE above plan. The Trust's worked workforce stood at 6,295 WTE, which remains 50 WTE below the budgeted establishment, with temporary staffing continuing to be utilised to support service delivery and maintain safe staffing levels where substantive workforce gaps remain.

The Trust continues to operate with a substantive workforce below funded establishment levels and remains reliant on bank and agency staffing within a number of key services. However, the Month 6 position reflects an improvement in workforce affordability, with expenditure ending the month £67.5k below budget. Whilst the year-to-date position remains adverse at £405.4k overspent, this represents a reduction from previous months and indicates that workforce control measures are beginning to have a positive impact. Temporary staffing expenditure remains an area of focus as services balance operational pressures, patient demand and safe staffing requirements.

Looking forward, the Trust will continue to focus on reducing temporary staffing utilisation through targeted recruitment, retention initiatives, establishment reviews and workforce redesign programmes. Organisational change activity, strengthened workforce controls and vacancy management arrangements are expected to support delivery of the Trust's financial recovery plans whilst maintaining safe, high-quality services. Continued oversight through the Workforce Controls Framework, enhanced establishment management and robust workforce planning will be essential to improving workforce affordability and delivering the required efficiencies during 2026/27.

Total Workforce Plan



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
WTE Plan	6441	6444	6444	6421	6421	6363	6516	6540	6488	6454	6451	6344
WTE Actual	6708	6656	6629	6649	6627	6688	6399	6358	6374	6383	6419	6364

In Month 6, actual contracted workforce increased to 6,364 WTE, compared to 6,419 WTE in Month 5. Planned workforce levels reduced from 6,451 WTE to 6,344 WTE, resulting in workforce utilisation being 20 WTE above plan, compared to 33 WTE below plan in Month 5. This represents a positive movement during the month, with overall workforce utilisation now exceeding the planned workforce position.

Whilst overall workforce utilisation is above plan, the Trust's worked workforce remains below establishment at 6,295 WTE, equating to 50 WTE below the budgeted workforce level. As a result, the Trust continues to utilise bank and agency staffing within a number of services to maintain safe staffing levels and respond to operational pressures. Continued focus on recruitment, retention, workforce productivity, establishment management and service redesign will be required to further reduce reliance on temporary staffing, improve workforce affordability and ensure workforce capacity remains aligned to service demand, quality requirements and the Trust's financial recovery objectives.

Bank WTE & Spend Analysis by staff group

Torbay and South Devon NHS Foundation Trust

Month 6	M6 Budget WTE	M6 Worked WTE	Variance of worked to budget	M6 Budget £	M6 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Any other Staff (Board Members)	0	0	0	£14,966	£0	-£14,966	£83,800	-£2,254	-£86,054
Medical and Dental	46	25	-21	£501,230	£405,876	-£95,354	£3,007,378	£2,864,550	-£142,828
NHS Infrastructure Support	43	44	1	£136,992	£158,648	£21,656	£827,948	£813,661	-£14,287
Nursing, Midwifery and Health Visiting Staff	74	91	17	£389,942	£512,294	£122,352	£2,401,924	£2,900,368	£498,444
Registered Scientific, Therapeutic and Technical staff	3	10	8	£30,099	£66,837	£36,738	£180,595	£314,759	£134,164
Support to Clinical Staff	93	154	61	£367,159	£578,477	£211,318	£2,202,954	£3,651,983	£1,449,029
Grand Total	**259**	**324**	**65**	**£1,440,388**	**£1,722,133**	**£281,745**	**£8,704,599**	**£10,543,067**	**£1,838,468**

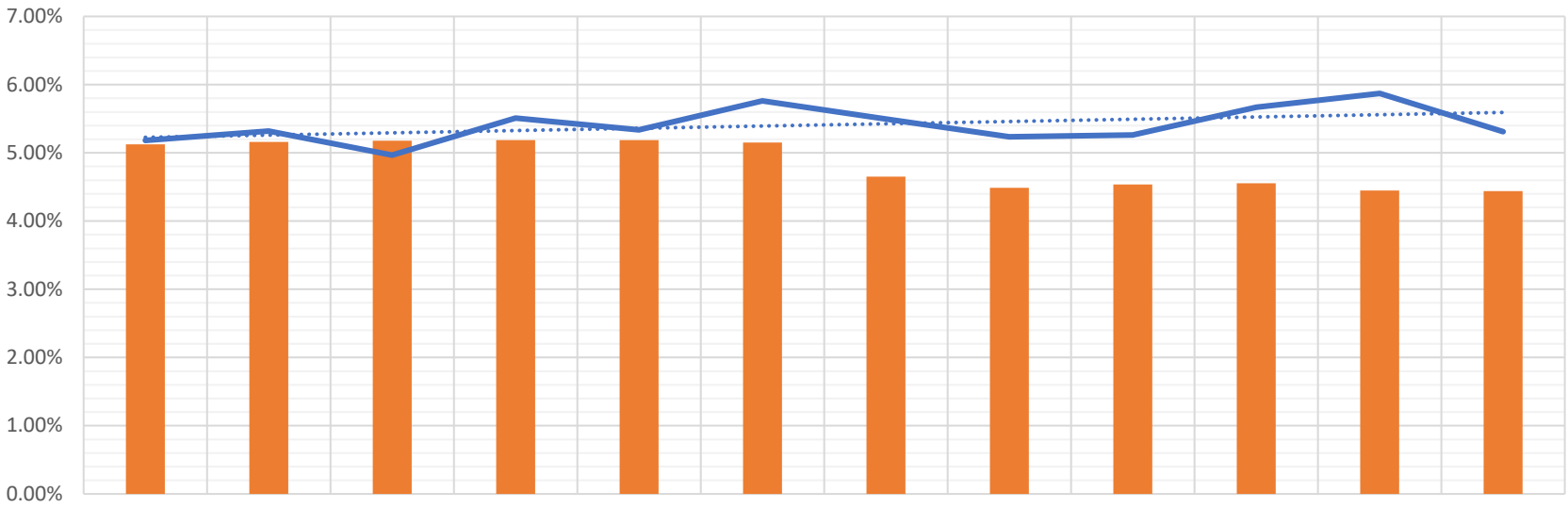
Bank utilisation increased further in Month 6 to 324 WTE, representing 65 WTE above the budgeted level of 259 WTE. This increase demonstrates the continued reliance on bank staffing to support service delivery, maintain safe staffing levels and address workforce shortages across a number of services. Whilst lower than previous months in some staff groups, bank utilisation remains significantly above planned levels overall.

Bank expenditure was £281.7k above budget in-month, resulting in a cumulative year-to-date overspend of £1.84m. The largest variance continues to relate to registered nursing and clinical staffing groups, reflecting ongoing workforce gaps, recruitment challenges and service pressures. The continued overspend highlights the extent to which bank staffing remains necessary to maintain workforce capacity and support safe service delivery.

Whilst bank staffing continues to represent a significant cost pressure, it remains a more cost-effective and flexible alternative to agency staffing in many areas and supports the Trust's objective of minimising higher-cost temporary workforce expenditure wherever possible. However, the sustained level of bank utilisation indicates that substantive workforce shortages remain a key challenge and continue to impact workforce affordability.

The Trust will continue to prioritise substantive recruitment, retention, workforce redesign and vacancy management initiatives to reduce reliance on temporary staffing over time whilst maintaining safe and effective services. Continued scrutiny of bank utilisation through the Workforce Controls Framework, together with strengthened workforce planning and establishment management arrangements, remains a key component of the Trust's financial recovery programme and workforce affordability strategy.

Bank Spend vs Budget



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Plan Bank %	5.12%	5.16%	5.18%	5.19%	5.19%	5.15%	4.65%	4.49%	4.54%	4.56%	4.45%	4.44%
Actual Bank %	5.18%	5.32%	4.97%	5.51%	5.34%	5.76%	5.49%	5.23%	5.26%	5.67%	5.87%	5.31%

Actual Bank utilisation has remained above plan throughout the year, with utilisation ranging from 4.97% to 5.87%. Following a reduction in April and May, bank usage increased steadily through the summer months, peaking at 5.87% in August. Whilst utilisation reduced to 5.31% in September, it remained significantly above the planned level of 4.44% and above the overall year-to-date average.

The sustained variance against plan indicates an ongoing reliance on bank staffing to support service delivery, maintain safe staffing levels and manage workforce pressures across a number of services. Although bank staffing remains the Trust's preferred temporary staffing solution in comparison to agency use, utilisation continues to exceed planned levels and remains a significant contributor to workforce cost pressures.

Reducing reliance on temporary staffing remains a key workforce priority. Continued focus on substantive recruitment, retention, sickness absence reduction, workforce redesign, workforce productivity and effective vacancy management will be required to address underlying workforce gaps and deliver a more sustainable workforce position during the remainder of 2026/27. Alongside this, ongoing scrutiny through the Workforce Controls Framework will be essential to ensure temporary staffing utilisation is appropriately challenged, controlled and aligned to service need.

Agency WTE and Spend Analysis by staff group

Torbay and South Devon NHS Foundation Trust

Month 6	M6 Budget WTE	M6 Worked WTE	Variance of worked to budget	M6 Budget £	M6 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Medical and Dental	9	10	2	£162,033	£242,290	£80,257	£989,011	£1,053,640	£64,629
NHS Infrastructure Support	0	3	3	£541	£23,340	£22,799	£3,246	£97,791	£94,545
Nursing, Midwifery and Health Visiting Staff	11	37	25	£42,138	£191,399	£149,261	£252,828	£1,235,815	£982,987
Registered Scientific, Therapeutic and Technical staff	14	3	-12	£130,797	£26,157	-£104,640	£784,782	£173,105	-£611,677
Support to Clinical Staff	1	0	-1	£5,274	£0	-£5,274	£31,644	£9,050	-£22,594
Grand Total	**36**	**53**	**17**	**£340,783**	**£483,186**	**£142,403**	**£2,061,511**	**£2,569,401**	**£507,890**

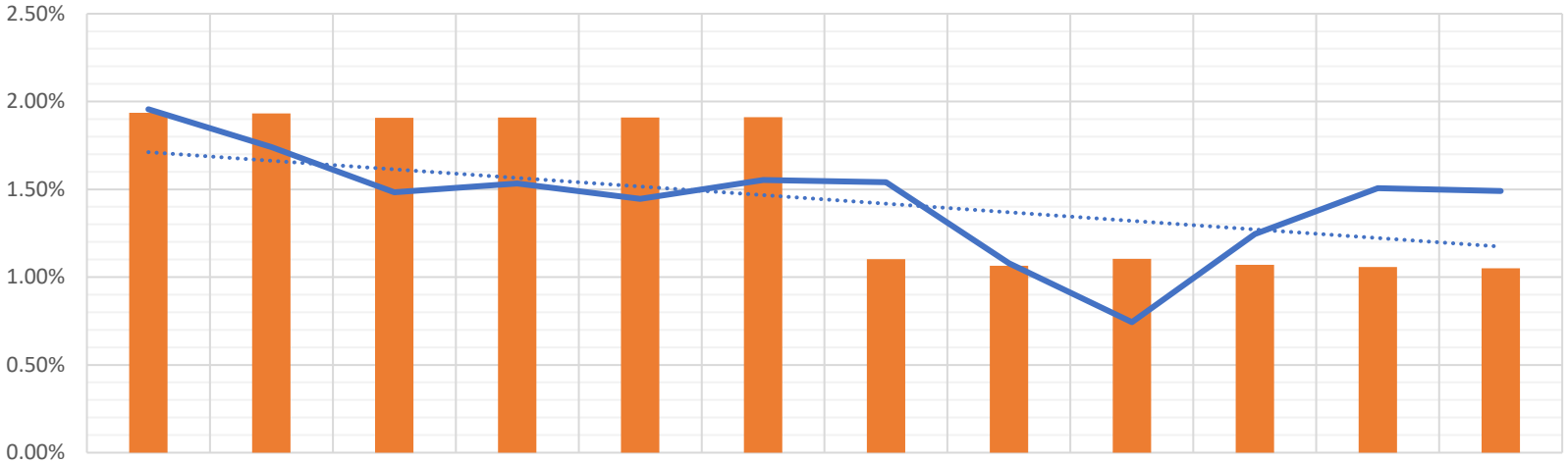
Agency utilisation reduced in Month 6 to 53 WTE, compared to 59 WTE in Month 5, but remains above the budgeted level of 36 WTE, resulting in a variance of 17 WTE. Whilst this represents an improvement on the previous month, it continues to reflect reliance on agency staffing in a small number of services experiencing persistent recruitment and retention challenges, particularly where bank staffing is not consistently available to meet operational requirements.

Agency expenditure was £142k above budget in-month, generating a cumulative year-to-date overspend of £508k. Although utilisation and expenditure have reduced slightly compared to Month 5, agency spend remains a significant financial pressure and continues to highlight workforce gaps that cannot yet be fully addressed through substantive recruitment or bank staffing solutions.

Agency deployment continues to be closely monitored through the Workforce Controls Framework, with robust approval processes in place to ensure agency usage is limited to essential requirements that support safe and effective service delivery. The reduction in Month 6 is encouraging; however, utilisation remains materially above plan and reinforces the need to accelerate interventions aimed at reducing temporary staffing reliance.

Focus will remain on strengthening workforce planning, vacancy management, targeted recruitment, retention and sickness absence reduction initiatives, alongside workforce redesign programmes. Sustained progress in these areas will be critical to reducing agency dependency, improving workforce affordability and delivering a more sustainable workforce position during the remainder of 2026/27.

Agency Spend vs Budget



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Plan Agency %	1.94%	1.93%	1.91%	1.91%	1.91%	1.91%	1.10%	1.06%	1.10%	1.07%	1.06%	1.05%
Actual Agency %	1.96%	1.74%	1.48%	1.53%	1.44%	1.55%	1.54%	1.08%	0.74%	1.24%	1.51%	1.49%

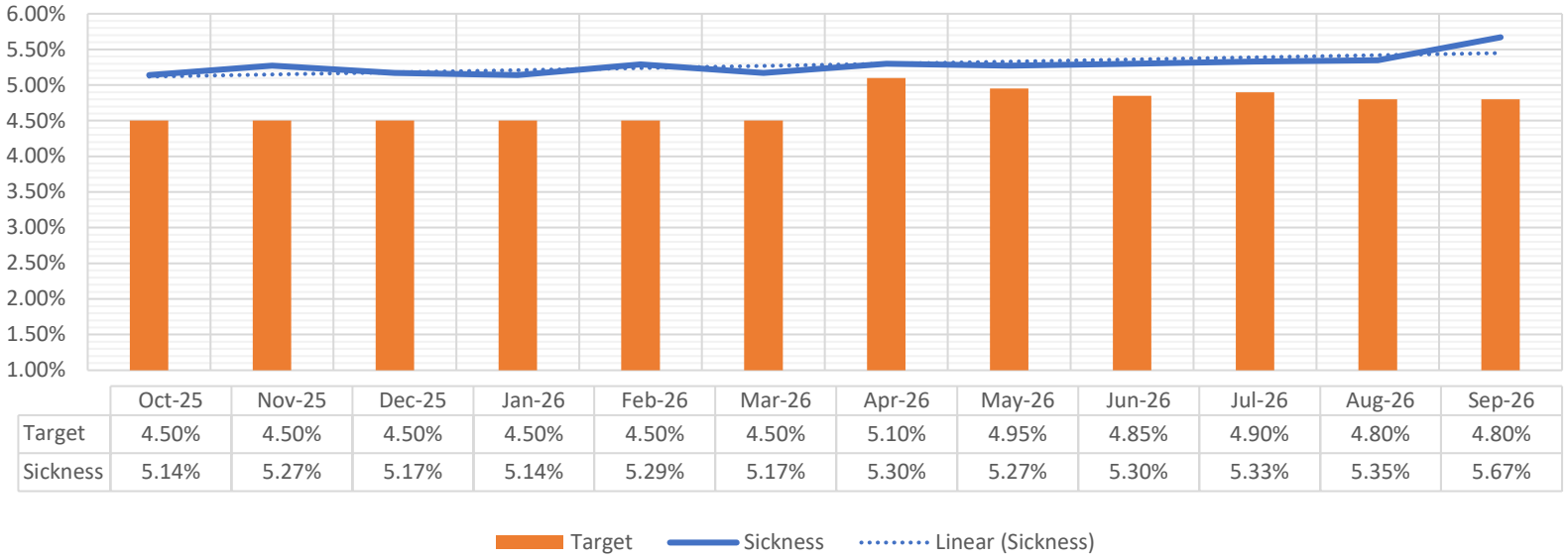
Actual Agency utilisation remained below plan for much of the year, demonstrating generally effective control of agency usage. Following a relatively stable, agency utilisation reduced significantly to 0.74% in June, the lowest level recorded during the year, before increasing to 1.24% in July, 1.51% in August and remaining elevated at 1.49% in September.

Although agency utilisation reduced marginally during September, it remains 0.44% above the planned level of 1.05% and continues to exceed plan by a significant margin. This reflects the continued agency utilisation reported in Month 6 and indicates that operational pressures and workforce shortages in a small number of services continue to require agency staffing support where substantive recruitment and bank staffing solutions are insufficient to meet demand. Whilst agency utilisation remains considerably lower than bank utilisation, the sustained increase since June highlights an ongoing reliance on agency staffing and continues to contribute to the adverse temporary staffing financial position.

Overall, agency reliance remains below the levels seen during the first half of the year, and the longer-term trend continues to demonstrate improved control compared with historical agency usage patterns. However, the flattening of the recent improvement and continued utilisation above plan reinforce the need to accelerate substantive recruitment, improve retention, reduce sickness absence and progress workforce redesign initiatives.

Sickness

Last Month (Aug 26)	Current Month (Sep 26)	Target	Change from last month	Performance against target
5.35%	5.67%	<4.80%	↑	



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	5.10%	4.95%	4.85%	4.90%	4.80%	4.80%
Sickness	5.14%	5.27%	5.17%	5.14%	5.29%	5.17%	5.30%	5.27%	5.30%	5.33%	5.35%	5.67%

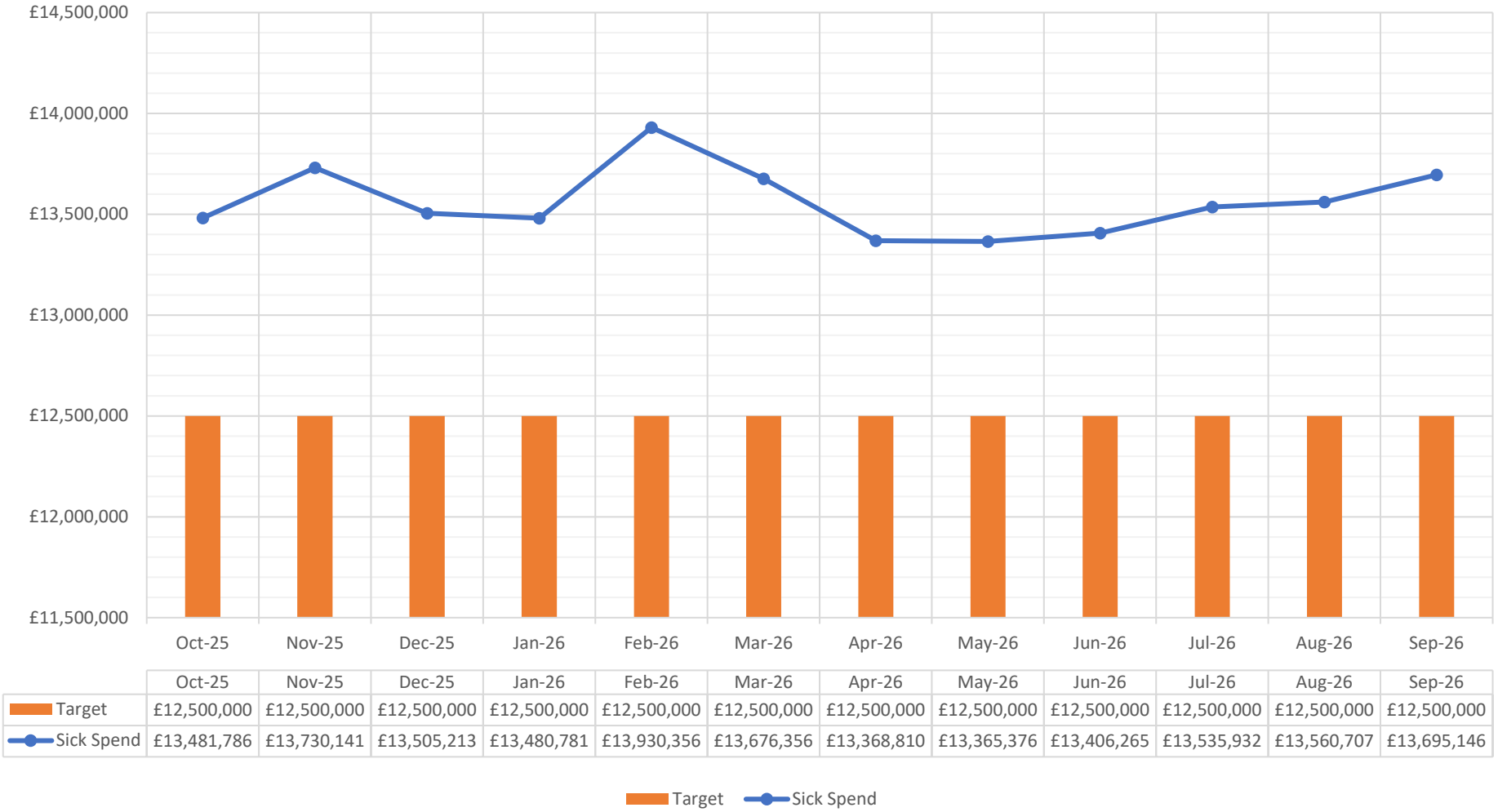
Target Sickness Linear (Sickness)

In September 2026, sickness absence increased to 5.67%, compared to 5.35% in August, and remains significantly above the Trust target of 4.80%. This represents the highest sickness absence rate reported during 2026/27.

Whilst sickness absence remained relatively stable at around 5.1%-5.4% for much of the year, September saw a notable increase of 0.32 percentage points month-on-month. As a result, the gap between actual performance and target has widened to 0.87 percentage points, compared with 0.55 percentage points in August, indicating that the organisation has moved further away from its planned trajectory.

Overall, sickness absence continues to represent one of the Trust's most significant workforce challenges, reducing workforce capacity and increasing operational pressures across services. The longer-term trend remains upward, with sickness absence increasing from 5.14% in October 2025 to 5.67% in September 2026, suggesting that existing interventions have not yet delivered a sustained organisational improvement. A detailed review of sickness absence is therefore underway to better understand the underlying causes and key drivers of absence across the organisation, including variations by staff group, service area and reason for absence. This work will inform a targeted improvement plan focused on reducing absence, improving staff wellbeing, strengthening management capability, supporting earlier intervention and attendance management.

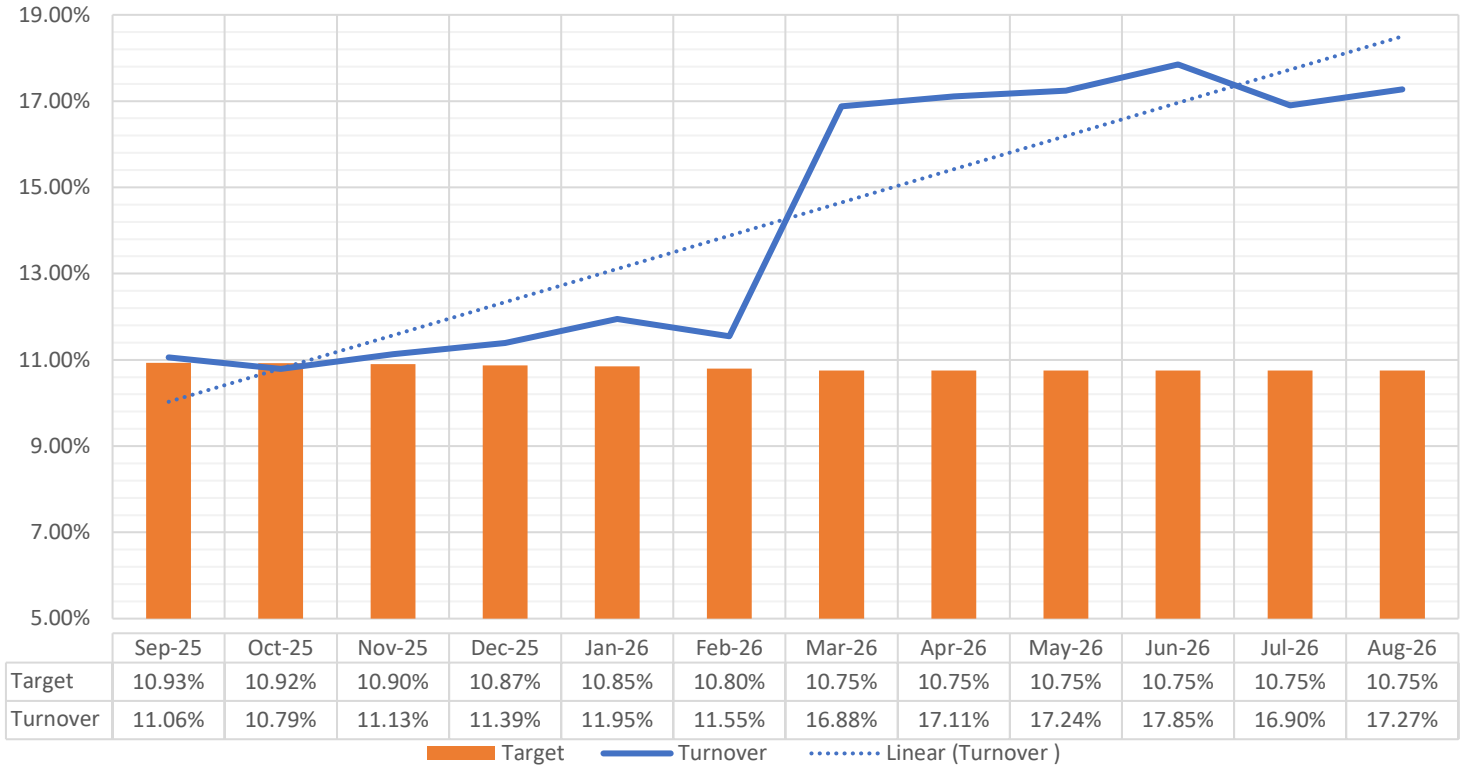
Sickness Cost



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Target	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000	£12,500,000
Sick Spend	£13,481,786	£13,730,141	£13,505,213	£13,480,781	£13,930,356	£13,676,356	£13,368,810	£13,365,376	£13,406,265	£13,535,932	£13,560,707	£13,695,146

Turnover

Last Month (Jul 26)	Current Month (Aug 26)	Target	Change from last month	Performance against target
16.90%	17.27%	<12%	↑	



	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Target	10.93%	10.92%	10.90%	10.87%	10.85%	10.80%	10.75%	10.75%	10.75%	10.75%	10.75%	10.75%
Turnover	11.06%	10.79%	11.13%	11.39%	11.95%	11.55%	16.88%	17.11%	17.24%	17.85%	16.90%	17.27%

In August 2026, turnover increased slightly to 17.27%, up from 16.90% in July, and remains significantly above the Trust target of 10.75%.Turnover is reported as a rolling 12-month measure and therefore continues to reflect the significant workforce movement seen over the previous year, including organisational change activity and other one-off workforce events. As a result, improvements in current retention rates may take time to be reflected in the overall metric.

Whilst the increase from July is relatively small, turnover remains well above target and continues to present challenges for workforce stability, recruitment and retention. Continued focus on employee experience, wellbeing, retention and workforce stability will be required to support a sustained reduction in turnover over the remainder of 2026/27.

Appraisal

	Last Month (Aug 26)	Current Month (Sep 26)	Target	Change from last month	Performance against target
AfC Appraisal	75.15%	76.33%	>90%	↑	
Medical Staff Appraisal	77.70%	77.48%	>90%	↓	

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
AfC Appraisal	81.17%	79.10%	79.53%	79.04%	78.52%	77.65%	75.68%	72.64%	75.63%	75.30%	75.15%	76.33%
Medical Appraisal	69.51%	73.86%	71.48%	71.90%	68.98%	72.00%	72.08%	73.35%	72.59%	72.84%	77.70%	77.48%
Families & Community	81.80%	87.97%	84.96%	79.91%	77.87%	78.15%	78.16%	75.21%	79.80%	77.89%	76.82%	77.65%
Medicine & Urgent Care	78.24%	75.46%	77.10%	75.59%	76.55%	77.21%	73.35%	69.18%	73.71%	72.44%	73.06%	74.02%
Planned Care and Surgery	83.46%	83.24%	82.50%	84.83%	85.16%	83.22%	79.62%	76.82%	80.12%	81.61%	82.15%	83.65%
Shared Corporate Services	78.69%	75.60%	73.40%	74.62%	71.64%	69.10%	69.66%	67.98%	67.55%	67.05%	67.91%	69.29%
ASCT	65.77%	64.73%	62.50%	64.89%	62.56%	66.67%	66.52%	65.49%	65.02%	60.00%	58.18%	54.59%

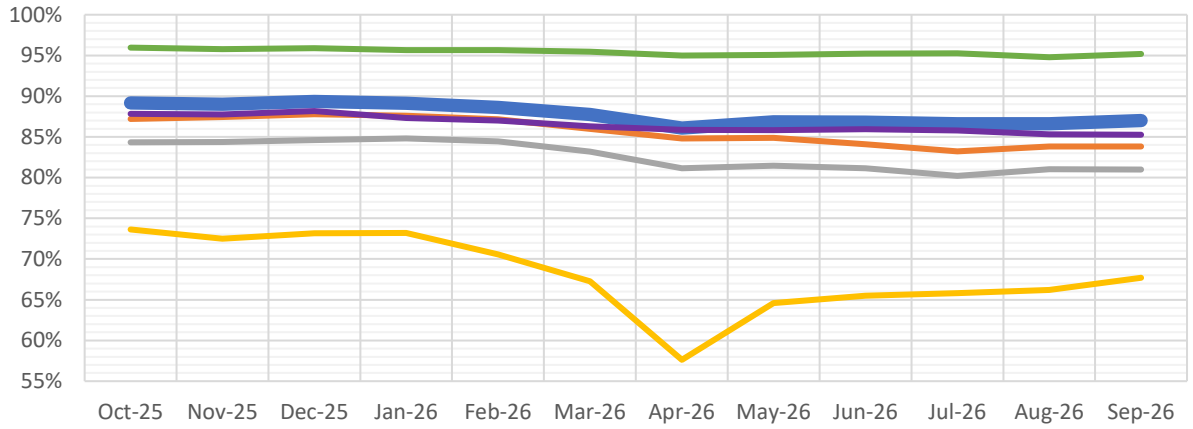
In September 2026, appraisal compliance continues to present a mixed picture. AfC appraisal compliance improved to 76.33%, up from 75.15% in August, whilst Medical appraisal compliance reduced slightly to 77.48%, compared to 77.70% in August. Both measures remain substantially below the Trust target of greater than 90%.At Care Group level, performance improved across most areas during the month. Planned Care & Surgery remains the highest-performing Care Group at 83.65%, followed by Families & Communities at 77.65%. Medicine & Urgent Care improved to 74.02%, whilst Shared Corporate Services increased to 69.29%. ASCT remains the lowest-performing area at 54.59%, having continued its downward trend over recent months.

Overall, appraisal compliance remains significantly below target across both AfC and Medical staff groups. Whilst there have been modest improvements in AfC compliance and across several Care Groups, progress remains inconsistent. The introduction of a stronger focus on career conversations through the appraisal process is expected to increase staff engagement and support improvement in appraisal completion rates over time.

Targeted action will continue through Care Group performance management arrangements, with particular focus on areas of persistent low compliance to support sustained improvement over the second half of 2026/27.

Mandatory Training

	Last Month (Aug 26)	Current Month (Sep 26)	Target	Change from last month	Performance against target
Combined Mandatory Training	86.62%	87.01%	>85%	↑	



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Overall Training %	89%	89%	89%	89%	89%	88%	86%	87%	87%	87%	87%	87%
Infection Control	87%	87%	88%	88%	87%	86%	85%	85%	84%	83%	84%	84%
Information Governance	84%	84%	85%	85%	84%	83%	81%	81%	81%	80%	81%	81%
Manual Handling	74%	72%	73%	73%	71%	67%	58%	65%	65%	66%	66%	68%
Safeguarding Children	88%	88%	88%	87%	87%	86%	86%	86%	86%	86%	85%	85%
Safeguarding Adults	96%	96%	96%	96%	96%	95%	95%	95%	95%	95%	95%	95%

In September 2026, overall mandatory training compliance improved to 87.01%, compared to 86.62% in August, and continues to exceed the Trust target of 85%.Whilst overall performance remains above target, variation continues across individual training subjects. Safeguarding Adults continues to perform strongly at 95%, whilst Safeguarding Children remains stable at 85%. Manual Handling remains the lowest-performing subject area; however, compliance improved further to 68%, continuing the recovery from the low of 58% seen earlier in the year.

Overall, mandatory training compliance continues to be maintained above target despite ongoing operational pressures. The sustained improvement in Manual Handling compliance is particularly encouraging, although variation between training topics highlights the need for continued focus on targeted recovery actions in areas below target. Work is ongoing to improve compliance across all mandatory training requirements and ensure high levels of statutory and mandatory training completion are maintained across the organisation.

Finance

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 September 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- CIP delivery is on target with no variance to plan.
- Industrial Action Strike costs (£0.4m adverse),
- Income provision for activity lost due to EPR (£1.6m adverse)
- Undrawn ERF Reserve (£1.3m favourable)
- Other budget variances (£0.7m favourable) including significant overspends in ASC/CHC and Planned Care offset with other underspends and unallocated reserves.

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £6.4m relating predominantly to CIP and cost pressures on ASC/CHC operational budgets.
- Base case forecast suggests risk of £2.8m against planned ULP

Year to Date CIP position £0.0m variance to plan:

- CIP delivery YTD of £16.5m against a £16.5m target
- The percentage of schemes assessed as fully developed remains consistent with previous months c90% (£49m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£7.4m adverse) and with higher levels of delivery risk than previous months.

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.

Plan	YTD / Forecast	Measure	Month 06 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	(6.4)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(2.8)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	0.0
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(7.4)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	0.7
Cash Plan	YTD	Unplanned Cash Support	0.0
Cash Plan	Forecast	Unplanned Cash Support	0.0

Capital programme update:

- Year to date capital plan is underspent (£0.7m)
- Forecast to deliver up to capital limits, £2.7m above initial plan, including additional allocation of £2.2m National PDC and £0.5m increase to CDEL allocation.

Cash Update:

- The Trust closing cash balance for Month 6 was (£15.1m) below plan, due to not drawing £10.193m PDC Revenue Support (per the plan to M06), with remaining £4.9m shortfall related to a receipt of £6.2m from Torbay Council after the ledger close.
- The Trust has submitted an application for £10.193m PDC Revenue Cash Support in M07 for drawdown in M08 with the expectation to repay in full in M12, reflecting the agreed 2026/27 plan.

Workforce Update

- The Trust is reporting worked WTEs 49 below plan, contracted WTEs 20 above plan.
- Agency and bank spend are both above plan and national cap targets. Bank and agency usage spiked in Month 5, reflecting increasing demand in peak leave periods and has reduced in Month 6.

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Torbay and South Devon NHS
NHS Foundation Trust

Data RAG rated against monthly Operational Plan trajectory **Bold number = national data**	Target March 2027	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Urgent and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)			1823	810	624	559	1283	621	755	953	1394	1365	1338	1612	1020
Ambulance handovers - time lost over 15 mins - Plan										641	676	623	681	674	662
Average handover time (mins) - Actual			60	33	29	27	45	30	31	38	47	49	47	55	39
Average handover time (mins) - Plan	30 mins		38	42	42	45	42	41	37	30	30	30	30	30	30
Total average time in ED (hours/minutes) - Actual	Reduction		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		655	585	549	520	918	740	734	676	839	805	950	1000	903
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan										394	655	469	423	394	606
Percentage of patients waiting over 12 hours in ED - Actual	7.7%		**9.7%**	**8.5%**	**8.3%**	**7.5%**	**13.6%**	**12.1%**	**10.6%**	**9.8%**	**11.7%**	**11.1%**	**12.9%**	**13.5%**	**12.2%**
Percentage of patients waiting over 12 hours in ED - Plan			8.2%	9.9%	8.4%	7.2%	7.0%	7.0%	6.1%	5.4%	8.3%	6.2%	5.2%	4.9%	8.5%
UEC 4-hour target (RAG against local trajectory to national target) - Actual	82%		**68.3%**	**68.0%**	**68.3%**	**70.8%**	**67.9%**	**66.4%**	**66.6%**	**64.2%**	**64.7%**	**65.3%**	**63.9%**	**63.4%**	**71.5%**
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%	77.0%	76.0%
% patient discharges pre-noon - Actual			21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%	13.6%	12.5%
% 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			8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%	18.0%	18.4%
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			13	16	9	9	13	8	7	9	9	11	11	19	21
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			110	109	84	94	83	76	47	76	135	169	182	169	160
RTT 65 week wait incomplete pathway - Plan	0		43	23	3	0	0	0	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	647	607	663	604	607	600	799	993	1088	1317	1249	1209
RTT 52 week wait incomplete pathway - Plan	292		673	586	505	449	383	327	268	805	941	1088	1009	929	850
RTT % Incomplete pathways <18 wks - Actual			**70.4%**	**69.3%**	**68.7%**	**67.5%**	**67.0%**	**66.8%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	**66.4%**	58.5%
RTT % Incomplete pathways <18 wks - Plan	73.8%		64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%	57.0%	59.0%	61.0%	62.0%
RTT Wait for first appointment <18 weeks - Actual			73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	62.4%	62.6%	60.7%	62.9%
RTT Wait for first appointment <18 weeks - Plan	74.0%		67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%	67.4%	66.8%	68.0%
Cancer: 28-day FDS - Actual			**67.3%**	**75.7%**	**76.2%**	**78.3%**	**60.6%**	**79.7%**	**75.7%**	**48.0%**	**45.5%**	**57.1%**	**58.5%**	**60.6%**	56.0%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%	57.4%	73.0%	77.0%	82.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			**63.2%**	**70.4%**	**71.1%**	**79.8%**	**75.2%**	**67.1%**	**60.1%**	**58.5%**	**48.9%**	**53.6%**	**57.9%**	**70.0%**	65.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%	78.8%	79.2%	79.9%	79.5%
Cancer: No of patients waiting >62 days to start treatment - Actual			176	132	91	119	159	214	201	276	288	347	272	276	264
Cancer: No of patients waiting >62 days to start treatment - Plan															
Cancer: % of patients > 62 days to start treatment - Actual			7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	12.0%	8.9%	9.5%	8.9%
Cancer: % of patients > 62 days to start treatment - Plan															
Diagnostics - proportion waiting over 6 weeks - Actual			**36.8%**	**29.4%**	**28.4%**	**30.4%**	**35.8%**	**30.6%**	**37.4%**	**39.4%**	**34.6%**	**25.4%**	**23.1%**	**22.2%**	21.5%
Diagnostics - proportion waiting over 6 weeks - Plan	14.9%			5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%	29.2%	27.7%	25.6%	23.9%	21.4%

RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

Torbay and South Devon NHS Foundation Trust

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RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Moderate	Trustwide	Trend			43	29	35	40	21	39	32	41	37	33	37	49	229
Reported Incidents - Severe	Trustwide	<6		4	3	3	3	4	0	5	1	5	7	8	4	10	35
Reported Incidents - Death	Trustwide	<1		0	0	3	4	4	1	4	0	1	1	1	4	1	8
Medication errors resulting in moderate or more severe harm	Trustwide	<1		0	1	2	3	0	1	2	0	1	0	4	0	2	7
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide	Trend			28	20	20	26	16	23	22	30	23	15	20	24	134
Never Events	Trustwide	<1		0	0	0	0	1	0	0	0	0	0	0	0	2	2
Number of Patient Safety Incident Investigations (PSII)	Trustwide	Trend		3	1	0	0	1	0	2	1	0	0	0	0	2	
Formal complaints - Number received	Trustwide	<20		25	27	17	22	20	18	28	22	14	27	33	35	17	148
Formal complaints - not acknowledged in 3 days	Trustwide	Trend		20	13	15	17	19	11	24	17	11	16	21	28	10	
Formal complaints - closed in 6 months	Trustwide	Trend		18	13	13	16	15	7	11	9	9	21	11	13	17	
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		89.65	91.46	92.61	94.03	92.26	93.05	94.12	95.98	98.36	98.87	100.26			
Standardised Hospital Mortality Rate (SHMI)	Trustwide	100		0.96	0.96	0.97	0.96	0.94	0.94	0.94	0.96	0.97	1.000				
Safer staffing fill rate - ICO - Day time	Trustwide	90% - 110%		91.2%	90.2%	92.1%	92.0%	91.5%	90.4%	90.6%	94.3%	91.3%	91.6%	90.8%	90.0%	89.7%	
Safer staffing rate - ICO - Night time	Trustwide	90% - 110%		95.1%	95.3%	96.6%	95.6%	94.1%	95.4%	95.6%	98.0%	94.1%	93.3%	93.9%	95.3%	94.6%	
Care Hours Per Patient Per Day: Day	Trustwide	Trend		4.1	4.1	4.2	4.2	4.1	4.1	4.1	4.4	4.2	4.3	4.2	4.1		
Care Hours Per Patient Per Day: Night	Trustwide	Trend		3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.5	3.4	3.4	3.4	3.3		
Number of Healthcare Associated Infection: MRSA	Trustwide	Trend			0	0	0	0	0	0	0	0	0	0	0	0	
Number of Healthcare Associated Infection: E-Coli	Trustwide	Trend			9	3	8	6	8	6	3	8	4	6	5	6	
Number of Healthcare Associated Infection: MSSA	Trustwide	Trend			3	5	5	2	3	1	3	1	3	2	7	3	
Nutrition risk assessment within 24 hours	Trustwide	>95%		92.1%	92.3%	92.3%	92.5%	92.6%	91.3%	92.5%							
Falls for 1000 bed days	Trustwide	<5.5		4.3	6.0	4.9	5.4	7.2	5.6	5.9	6.7	6.4	5.3	6.7	5.8	5.9	
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	84.8%	65.0%	58.5%	59.5%	79.5%	67.5%		
Stroke - % patients admitted to stroke unit within 4 hours	Trustwide	>50%		50.0%	49.1%	34.1%	52.9%	34.0%	38.0%	49.1%	17.8%	20.4%	38.2%	43.6%	33.3%	55.3%	
30-day readmission rate	Trustwide	Trend			13.5%	13.8%	13.1%	12.4%	11.9%	13.0%	8.3%	12.1%	12.7%	11.2%	12.6%	12.1%	
Mixed Sex Accommodation breaches	Trustwide	Trend		220	190	160	222	186	134	180	169	160	181	268	230	222	1230
Follow ups 6 weeks past to be seen date	Trustwide	6400		18135	16900	17610	17827	16967	16835	18638							
Maternity 1:1 care in labour (%)	Trustwide	Trend				98.6%	100.0%	100.0%	98.6%	100.0%							
Maternity 1:1 % Admission to SCBU (full term)	Trustwide	Trend				7.8%	5.1%	10.9%	4.4%	8.8%	8.5%	3.4%	2.1%	3.5%	7.4%	6.3%	
Maternity Stillbirths	Trustwide	Trend				0	0	1	0	0	0	0	1	0	1	0	
Maternity Smoking at time of delivery	Trustwide	Trend				5	8	3	3	3	4	1	6	5	5	6	

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Maternity 3rd and 4th degree tears - total (%)	Trustwide	Trend				6.8%	2.5%	3.1%	5.6%	3.0%	4.3%	2.8%	2.6%	7.1%	8.3%	4.6%	
Maternity PPH>1500mls (%)	Trustwide	Trend				3.6%	0.7%	4.3%	1.4%	1.6%	2.2%	1.9%	4.5%	6.3%	4.5%	3.0%	
Maternity Number of births	Trustwide	Trend						141	148	123	138	158	158	161	138	168	
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.1%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.4%	5.4%		
Appraisal Completeness	Trustwide	>90%		80.5%	80.5%	78.8%	78.9%	78.7%	78.1%	77.3%	75.5%	72.7%	75.4%	75.1%	75.3%	76.4%	
Mandatory Training Compliance	Trustwide	>85%		85.5%	86.2%	86.2%	87.9%	85.9%	85.0%	84.1%	85.3%	83.3%	83.5%	83.5%	83.6%	83.6%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.8%	10.8%	11.1%	12.8%	12.9%	10.6%	15.0%	15.4%	10.2%	10.1%	10.2%	12.4%	11.0%	

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RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	17.8%						17.8%
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%		6.9%			6.7%			5.7%							
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							492	436	443						
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		215	264	229	207	243	191	204							2688
Community waiting list	Trustwide					7688	7004	7236	8040	7058	6465	5349	6719	5847	5813	6730	
Community Hospital - Admissions (general)	Trustwide	NONE SET		190	241	208	211	242	195	204	187	214	206	201	187	203	2478
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		15.6	13.9	12.8	14.0	14.2	12.9	15.2	18.0	14.7	14.9	17.8	15.1	14.4	14.2
Community Hospital % patient discharges pre-noon	Community Hospital	33%		48.0%	45.0%	47.0%	44.0%	45.0%	48.0%	50.0%	50.0%	45.0%	51.0%	49.0%	46.0%	44.0%	
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		90.4%	91.3%	94.5%	91.8%	92.6%	93.8%	91.0%	78.5%	83.6%	70.5%	78.5%	70.5%	77.8%	76.1%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		251	299	220	243	230	194	211	65	128	122	130	129	117	691
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		24.6	24.6	24.6	22.1	23.4	24.6	25.9							25.9
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		687.9	737.6	742.8	729.7	753.3	734.9	745.4	729.7						729.7
Proportion of clients receiving direct payments	Trustwide	25%		17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	17.8%						17.8%
% reablement episodes not followed by long term SC support	Trustwide	83%		88.9%	88.6%	88.9%	89.1%	89.1%	88.9%	94.2%	95.7%						95.7%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		30.9%	38.0%	38.9%	37.0%	37.9%	41.0%	33.6%	29.9%	23.8%	29.1%	40.6%	42.3%	37.2%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		91.4%	91.1%	93.1%	92.9%	92.7%	95.8%	93.4%	83.0%	83.1%	87.7%	89.6%	93.7%	94.5%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	57.4%	50.4%	50.6%	53.9%	69.3%	65.0%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		29	21	21	20	27	44	44	56	70	61	66	65	58	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	62.8%	60.4%	59.6%	56.8%	56.8%	58.5%	
On the day cancellations for elective operations	Trustwide	<0.8%		0.7%	0.8%	0.7%	0.9%	0.9%	0.7%	0.5%	0.0%	0.0%					
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		11	17	17	14	11	11	11	6	8					
Theatre Utilisation	Trustwide	85%		82.7%	83.2%	81.8%	80.3%	82.8%	81.5%	81.3%	66.0%	73.4%	68.0%	73.4%	72.3%	83.2%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		15.9%	14.6%	15.6%	15.5%	16.9%	16.3%	16.1%	19.7%	19.8%	19.8%	18.2%	19.2%	18.2%	
Bed Occupancy	Acute	90%		96.8%	96.7%	96.5%	95.2%	97.5%	97.2%	97.2%	93.9%	95.1%	93.2%	95.7%	96.5%	96.2%	
% patient discharges pre-5pm	Acute	75%		68.3%	66.0%	68.8%	69.5%	68.9%	68.1%	66.8%	55.3%	60.6%	64.1%	69.6%	67.4%	68.1%	

Torbay and South Devon NHS Foundation Trust

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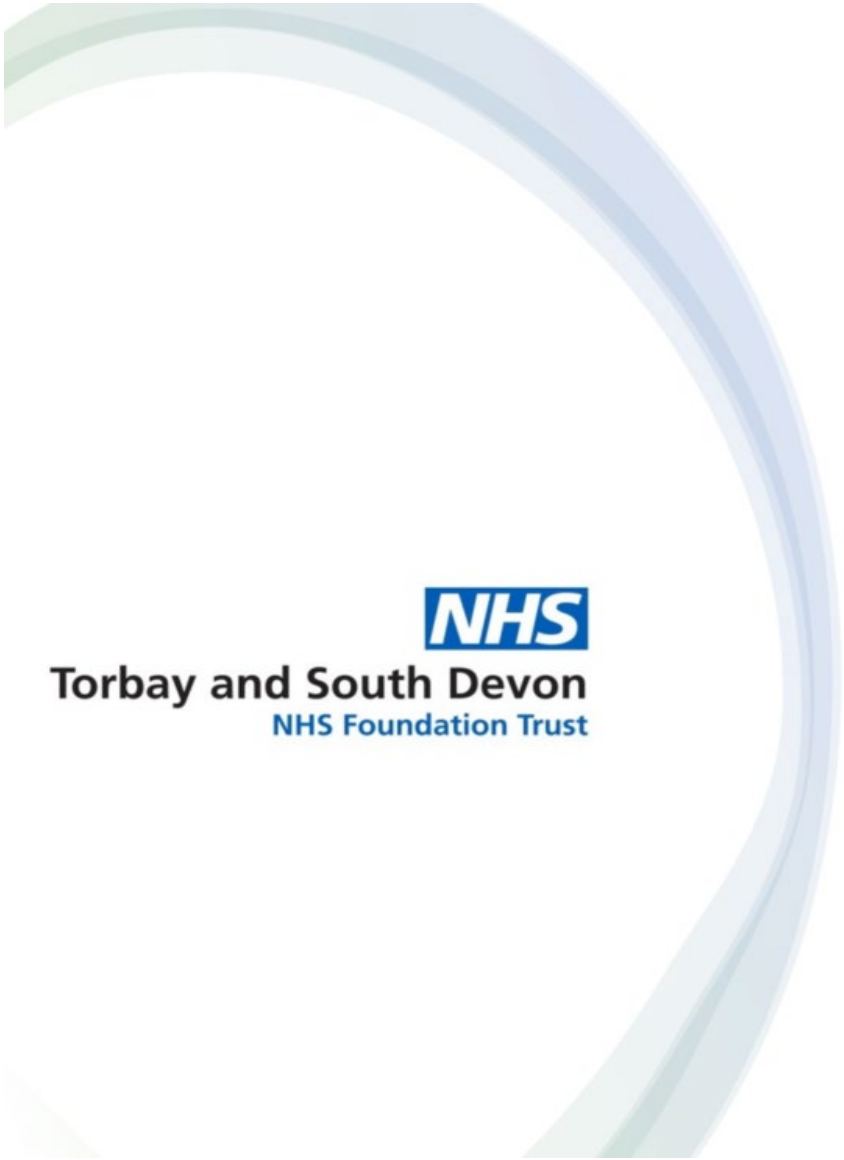
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year to date
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		9.3%	11.9%	7.8%	9.0%	10.7%	10.1%	10.3%							
Percentage of inpatients with No Criteria to Reside (South Devon GP registered patients)	Acute	<5%		10.0%	12.8%	10.6%	14.0%	14.4%	15.1%	12.8%							
Average length of stay (days) - discharges from main acute wards	Acute			6.1	5.9	5.6	6.3	7.0	6.9	6.8	7.7						
Number of patients >7 days LoS (daily average)	Acute	153		159.6	158.3	161.9	169.6	178.2	168.0	169.5	149.7	154.7	163.5	168.8	173.1	173.7	
Number of extended stay patients >21 days (daily average)	Acute	35		42.5	39.3	43.7	47.7	48.9	38.4	41.2	39.8	47.2	46.8	52.5	55.5	52.7	
Ambulance handover delays > 30 minutes	Acute			1250	933	957	813	1277	965	1170	1228	1390	1363	1299	1405	1222	7907
Ambulance handover delays > 60 minutes	Acute	0		764	203	121	103	450	135	167	303	480	494	460	593	301	2631
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.1%	64.7%	65.2%	63.9%	63.2%	71.4%	65.5%
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			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			25.6%	21.8%	21.3%	22.5%	25.5%	19.8%	18.1%	23.8%	23.4%	24.0%				
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			04:07	04:10	04:03	03:59	04:14	04:24	04:37	05:34	05:41	05:39	06:01	05:49	04:51	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			08:58	08:15	08:05	08:16	11:37	10:16	09:36	10:18	11:40	11:48	11:55	12:49	11:53	
Corridor Care - Emergency Department	Acute	0										963	940	1092	1090	1015	
Dementia - Find - monthly report	Trustwide	>90%		95.1%	94.9%	96.9%	94.6%	97.2%	95.8%	81.5%							96.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		77.8%	77.5%	71.4%	73.8%	75.6%	71.5%	72.0%							79.4%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		58.0%	60.6%	67.2%	63.5%	59.8%	52.5%	61.3%							62.3%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		72.2%	72.1%	74.4%	63.2%	50.3%	63.2%	77.1%							
ERF activity 2026/27 vs 2025/26 baseline																	
Day cases												86.2%	99.6%	105.5%	112.0%	110.0%	96.0%
Elective inpatient admissions												81.0%	74.4%	87.0%	69.0%	79.0%	77.0%
Admitted Patient Care Total												86.0%	98.0%	104.0%	108.0%	108.0%	94.0%
Outpatient - first appointment												68.0%	93.0%	97.0%	92.0%	102.0%	80.0%
Outpatient - first appointment with procedure												72.0%	119.0%	91.0%	86.0%	112.0%	90.0%
Outpatient - follow-up with procedure												73.0%	91.0%	93.0%	107.0%	96.0%	73.0%
Outpatient Appointment Total												70.0%	92.0%	94.0%	107.0%	96.0%	79.0%
ERF Income Grand Total (% above 2019/20)												83.0%	98.0%	107.0%	108.0%	102.0%	87.0%
Non-ERF activity 2026/27 vs 2025/26																	
Non-elective admissions												0%	0%	0%	0%		0%
UEC attendances (Type 1 and 3)												98.0%	102.9%	99.9%	98.7%		100.3%

Torbay and South Devon NHS
NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - September 2026

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
Year-to-date revenue variance to plan	Trustwide												-1.60%	-1.80%	-1.80%		
Year-to-date revenue variance to plan,excluding the impact of loss of DSF	Trustwide												0.00%	0.00%	0.10%		
Forecast revenue variance to plan	Trustwide												-1.90%	-1.90%	-1.80%		
Forecast revenue variance to plan, excluding the impact of loss of DSF	Trustwide												0.10%	0.10%	0.10%		
Recurrent forecast variance to planned underlying position	Trustwide												-2.30%	-2.30%	-2.30%		
Percentage of efficiency schemes assessed as high risk	Trustwide												0.00%	0.00%	0.00%		
Percentage efficiency delivery against plan year to date	Trustwide												92%	92%	100%		
Percentage forecast recurrent efficiency delivery against plan	Trustwide												65%	65%	64%		
Forecast cash support required from the system	Trustwide												None	None	None		
Year-to-date charge against CDEL as a percentage of forecast CDEL expenditure	Trustwide												46%	58%	100%		
Funding approval status of schemes in forecast	Trustwide												81%	96%	104%		
Forecast capital spend as a percentage of allocated system capital	Trustwide												100%	100%	100%		



Safer Staffing Dashboard - September-202

Report Version: 1

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Safer Staffing Dashboard - Inpatient Wards - September-2026

Torbay and South Devon NHS
NHS Foundation Trust

Our priorities for 2025-2026: Triangulation of our workforce metrics and Patient Sensitive Indicators

Report Version: 1 (Published: 06/10/2026 14:46)

	Ward	Beds		Staffing Fill Rates				Actual Staffing Split						Care Hours Per Patient Day (CHPPD)										HR Metrics			Temporary Staffing		Ward Accred.1	PATIENT SENSITIVE INDICATORS											
				Days		Nights		RN v Care Staff Splits				Day v Night Split		Days				Nights														Safety						Feedback		
								Days		Nights				RN / Midwives		Care Staff		Overall Day		RN / Midwives		Care Staff		Overall Night						Red Flags Raised			Falls					FFT		
		Establ. Beds	Bed Occ.	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	Sickness Rate (Jul-26)	Turnover Rate (Aug-26)	Vacancy Rate (Aug-26)	Prop. Bank Hours (Aug-26)	Prop. Agency Hours (Aug-26)		ETeC Red Flags2	All Red Flags	Mod. Harm Incs and Above	PUs G2+ Acq. in Our Care	No Harm	Harm	Medicine Errors	% Obs Taken on Time (Mar-26)	Patient Complaints	% Positive Resp. (Jul-25)	Number of Resp. (Jul-25)
Families and Communities	Brixham Hosp Ward	20	97.5%	132.6%	84.3%	100.4%	99.5%	51.2%	48.8%	40.2%	59.8%	53.1%	46.9%	1.2	1.6 (+0.4)	1.8	1.6 (-0.3)	3.1	3.2 (+0.1)	1.1	1.1 (+0.0)	1.7	1.7 (-0.0)	2.8	2.8 (-0.0)	4.0%	11.6%	1.0%	0.0%	0.0%	#VALUE!	0	0	1	0	2	1	0	88.0%	0	-	-
	Dawlish Hosp Ward	16	90.2%	110.3%	81.0%	112.5%	106.1%	47.6%	52.4%	51.4%	48.6%	53.6%	46.4%	1.5	1.6 (+0.2)	2.2	1.8 (-0.4)	3.7	3.4 (-0.3)	1.4	1.5 (+0.2)	1.4	1.4 (+0.1)	2.7	3.0 (+0.3)	6.1%	12.6%	17.5%	3.4%	0.0%	#VALUE!	0	3	1	0	5	6	0	90.2%	0	-	-
	John Macpherson	18	56.3%	55.1%	87.7%	83.0%	69.6%	48.5%	51.5%	70.5%	29.5%	59.1%	40.9%	3.4	1.9 (-1.5)	2.3	2.0 (-0.3)	5.7	3.9 (-1.8)	2.3	1.9 (-0.4)	1.1	0.8 (-0.3)	3.4	2.7 (-0.7)	9.9%	8.3%	-2.0%	12.4%	0.0%	#VALUE!	0	0	0	0	0	0	0	-	0	-	-
	Louisa Cary	19	55.2%	80.8%	90.8%	72.3%	118.3%	72.8%	27.2%	64.7%	35.3%	49.8%	50.2%	6.0	4.8 (-1.1)	2.0	1.8 (-0.2)	8.0	6.6 (-1.3)	6.0	4.3 (-1.7)	2.0	2.4 (+0.4)	8.0	6.7 (-1.3)	2.9%	17.9%	14.4%	5.4%	0.0%	#VALUE!	0	1	0	0	0	0	1	-	0	-	-
	Newton Abbot Hosp (General Ward)	30	96.7%	93.9%	109.4%	101.5%	117.2%	46.2%	53.8%	46.4%	53.6%	60.3%	39.7%	1.9	1.7 (-0.1)	1.9	2.0 (+0.2)	3.7	3.8 (+0.1)	1.1	1.2 (+0.0)	1.1	1.3 (+0.2)	2.3	2.5 (+0.2)	10.3%	13.5%	10.1%	4.6%	0.0%	#VALUE!	0	7	0	0	5	4	0	88.2%	0	-	-
	Newton Abbot Hosp (Stroke Ward)	30	99.4%	97.4%	108.2%	99.2%	113.7%	41.9%	58.1%	46.6%	53.4%	61.4%	38.6%	1.6	1.6 (-0.0)	2.0	2.2 (+0.2)	3.6	3.7 (+0.1)	1.1	1.1 (-0.0)	1.1	1.3 (+0.2)	2.2	2.4 (+0.1)	3.3%	13.1%	7.6%	4.8%	0.0%	#VALUE!	0	2	1	0	6	3	1	90.5%	0	-	-
	SCBU	10	73.0%	86.7%	74.5%	92.1%	37.4%	77.7%	22.3%	88.1%	11.9%	51.6%	48.4%	4.7	4.1 (-0.6)	1.6	1.2 (-0.4)	6.3	5.3 (-1.0)	4.7	4.4 (-0.4)	1.6	0.6 (-1.0)	6.3	4.9 (-1.4)	2.7%	16.6%	-1.2%	4.3%	0.0%	#VALUE!	0	0	0	0	0	0	0	-	0	-	-
	Totnes Hosp Ward	16	96.9%	100.1%	100.6%	101.7%	143.1%	39.9%	60.1%	41.6%	58.4%	52.8%	47.2%	1.4	1.4 (+0.0)	2.1	2.1 (+0.0)	3.4	3.5 (+0.0)	1.3	1.2 (+0.0)	1.3	1.8 (+0.5)	2.5	3.1 (+0.6)	5.5%	38.3%	21.7%	5.5%	0.0%	#VALUE!	0	0	1	0	4	3	0	87.8%	0	-	-
Medicine and Urgent Care	Cheetham Hill	28	100.0%	87.0%	85.5%	101.1%	100.8%	45.9%	54.1%	42.9%	57.1%	57.3%	42.7%	2.0	1.8 (-0.3)	2.5	2.1 (-0.4)	4.5	3.9 (-0.6)	1.2	1.2 (+0.0)	1.6	1.7 (+0.0)	2.9	2.9 (+0.0)	5.4%	6.1%	9.7%	11.5%	0.0%	#VALUE!	0	0	1	0	0	5	0	92.0%	0	-	-
	Coronary Care Unit	14	91.9%	95.7%	-	100.0%	-	100.0%	0.0%	95.9%	4.1%	55.0%	45.0%	3.6	3.4 (-0.2)	0.0	-	3.6	3.4 (-0.2)	2.7	2.7 (+0.0)	0.0	0.1 (+0.1)	2.7	2.8 (+0.1)	2.5%	6.6%	11.5%	4.0%	0.0%	#VALUE!	0	0	0	0	0	1	1	93.4%	0	-	-
	Dunlop	24	99.6%	89.9%	90.8%	100.0%	101.4%	53.1%	46.9%	49.7%	50.3%	52.9%	47.1%	1.9	1.7 (-0.2)	1.7	1.5 (-0.2)	3.6	3.3 (-0.3)	1.4	1.4 (+0.0)	1.4	1.5 (+0.0)	2.9	2.9 (+0.0)	4.8%	6.4%	6.0%	5.1%	0.0%	#VALUE!	0	0	0	0	3	1	0	95.5%	0	-	-
	EAU4	24	100.0%	88.7%	86.4%	98.0%	91.8%	56.2%	43.8%	57.2%	42.8%	47.9%	52.1%	2.4	2.1 (-0.3)	1.9	1.7 (-0.3)	4.4	3.8 (-0.5)	2.4	2.4 (-0.0)	1.9	1.8 (-0.2)	4.4	4.1 (-0.2)	7.3%	15.5%	16.2%	5.2%	0.0%	#VALUE!	0	0	0	0	2	2	3	90.6%	2	-	-
	George Earle	28	99.2%	85.9%	88.3%	100.0%	98.9%	44.8%	55.2%	43.1%	56.9%	58.0%	42.0%	2.1	1.8 (-0.3)	2.5	2.2 (-0.3)	4.6	4.0 (-0.6)	1.2	1.2 (+0.0)	1.7	1.6 (-0.0)	2.9	2.9 (-0.0)	8.5%	7.8%	9.1%	6.7%	0.0%	#VALUE!	0	0	1	0	1	2	1	93.7%	0	-	-
	McCallum - Short-Stay	17	96.8%	92.4%	73.7%	99.1%	102.9%	62.6%	37.4%	49.0%	51.0%	49.3%	50.7%	2.7	2.5 (-0.2)	2.0	1.5 (-0.5)	4.7	3.9 (-0.7)	2.0	2.0 (-0.0)	2.0	2.1 (+0.1)	4.0	4.0 (+0.0)	12.3%	3.0%	6.3%	5.2%	0.0%	#VALUE!	0	6	0	0	0	1	2	89.5%	0	-	-
	Midgley	26	99.5%	89.4%	77.4%	100.0%	95.8%	53.6%	46.4%	51.1%	48.9%	51.6%	48.4%	2.2	2.0 (-0.2)	2.2	1.7 (-0.5)	4.4	3.7 (-0.7)	1.8	1.8 (+0.0)	1.8	1.7 (-0.1)	3.6	3.5 (-0.1)	13.4%	13.4%	10.2%	5.3%	0.0%	#VALUE!	0	1	2	0	1	3	1	93.2%	1	-	-
	New Forrest	29	100.0%	80.1%	90.5%	96.7%	100.8%	52.5%	47.5%	48.9%	51.1%	49.1%	50.9%	2.0	1.6 (-0.4)	1.6	1.4 (-0.2)	3.6	3.0 (-0.5)	1.6	1.5 (-0.1)	1.6	1.6 (+0.0)	3.2	3.1 (-0.0)	8.1%	8.8%	-3.6%	8.2%	2.8%	#VALUE!	0	0	1	0	0	1	2	94.1%	0	-	-
	Simpson	28	100.0%	84.3%	87.3%	98.9%	112.5%	44.6%	55.4%	39.7%	60.3%	55.9%	44.1%	2.0	1.7 (-0.3)	2.4	2.1 (-0.3)	4.4	3.8 (-0.6)	1.2	1.2 (-0.0)	1.6	1.8 (+0.2)	2.8	3.0 (+0.2)	9.3%	7.4%	11.0%	6.6%	0.3%	#VALUE!	0	0	2	0	3	6	2	92.1%	0	-	-
Planned Care	Ainslie	26	99.4%	91.6%	93.4%	100.8%	126.4%	49.5%	50.5%	51.5%	48.5%	54.2%	45.8%	2.2	2.0 (-0.2)	2.2	2.1 (-0.1)	4.5	4.1 (-0.3)	1.8	1.8 (+0.0)	1.3	1.7 (+0.4)	3.1	3.5 (+0.4)	7.1%	7.7%	8.4%	5.2%	0.0%	#VALUE!	4	17	0	0	2	3	1	91.1%	0	-	-
	Allerton	29	99.4%	97.3%	113.7%	100.0%	133.4%	66.6%	33.4%	50.0%	50.0%	56.1%	43.9%	2.8	2.7 (-0.1)	1.2	1.4 (+0.2)	4.0	4.1 (+0.1)	1.6	1.6 (+0.0)	1.2	1.6 (+0.4)	2.8	3.2 (+0.4)	1.1%	16.2%	0.7%	5.1%	0.0%	#VALUE!	1	2	0	0	3	3	1	89.0%	0	-	-
	Cromie	25	100.0%	98.5%	95.2%	103.0%	114.4%	56.4%	43.6%	47.4%	52.6%	57.2%	42.8%	2.2	2.2 (-0.0)	1.8	1.7 (-0.1)	4.0	3.9 (-0.1)	1.3	1.4 (+0.0)	1.3	1.5 (+0.2)	2.7	2.9 (+0.2)	6.8%	1.4%	-8.0%	5.3%	0.0%	#VALUE!	2	4	0	0	0	5	1	91.1%	0	-	-
	Ella Rowcroft	16	81.7%	96.3%	94.1%	84.9%	118.6%	43.4%	56.6%	51.8%	48.2%	57.5%	42.5%	2.0	1.9 (-0.1)	2.7	2.5 (-0.2)	4.7	4.5 (-0.2)	2.0	1.7 (-0.3)	1.3	1.6 (+0.2)	3.3	3.3 (-0.1)	1.6%	8.0%	0.6%	5.2%	0.0%	#VALUE!	9	9	0	0	2	2	3	91.7%	0	-	-
	Intensive / Critical Care Unit	10	62.7%	80.9%	62.8%	71.9%	-	92.1%	7.9%	100.0%	0.0%	55.0%	45.0%	16.5	13.4 (-3.2)	1.8	1.2 (-0.7)	18.4	14.5 (-3.8)	16.5	11.9 (-4.6)	0.0	-	16.5	11.9 (-4.6)	5.4%	12.8%	22.6%	0.0%	0.0%	#VALUE!	0	0	2	0	0	0	2	9.1%	0	-	-
	Turner	18	98.2%	72.2%	86.4%	100.0%	113.3%	51.1%	48.9%	46.9%	53.1%	52.5%	47.5%	3.2	2.3 (-0.9)	2.6	2.2 (-0.4)	5.8	4.6 (-1.3)	1.9	1.9 (+0.0)	1.9	2.2 (+0.3)	3.9	4.1 (+0.3)	4.1%	3.8%	20.5%	3.8%	0.0%	#VALUE!	0	4	1	0	1	3	1	93.3%	0	-	-
	Warrington	17	98.5%	115.0%	96.1%	131.7%	127.0%	54.5%	45.5%	50.9%	49.1%	55.0%	45.0%	2.1	2.4 (+0.3)	2.1	2.0 (-0.1)	4.1	4.4 (+0.2)	1.4	1.8 (+0.4)	1.4	1.7 (+0.4)	2.7	3.6 (+0.8)	3.6%	6.4%	-6.9%	5.1%	0.0%	#VALUE!	1	2	0	0	0	0	0	91.6%	1	-	-
	ALL WARDS	518	93.5%	89.7%	90.9%	94.6%	108.1%	54.9%	45.1%	53.3%	46.7%	54.5%	45.5%	2.5	2.2 (-0.3)	2.0	1.8 (-0.2)	4.4	4.0 (-0.4)	1.9	1.8 (-0.1)	1.4	1.6 (+0.1)	3.3	3.3 (+0.0)	6.1%	11.0%	8.2%	5.5%	0.1%		17	58	14	0	40	55	23	91.5%	4	-	-

Below each RAGed figure are indicators giving the RAG status (where available) for past months with the status for the previous month given by the right-most indicator.
Below the Ward Accreditation statuses are (where available), indicators giving the previous accreditation statuses held by the ward.

1 Ward Accreditation for Maternity and Paediatrics will begin in 2025; the Intensive Care Unit has no accreditation and there is no intention to begin. Note also that the indicators below the current status represent previous accreditation statuses (regardless of when they were achieved) and not the accreditation statuses for the three months prior to the current month.

2 The collection of data for Red Flags concerning the lack of EToC provision began on the 4th of March 2025 so no data for this measure is available prior to that date.

Safer Staffing Dashboard - Inpatient Wards - September-2026 - Assurance

Torbay and South Devon NHS
NHS Foundation Trust

Measure	Assurance	Narrative	Mitigation	Actions

Measure			Summary1	Narrative	Mitigation	Actions
STAFFING METRICS						
Bed Occupancy			Limited	Inpatient bed occupancy increased slightly from 93.4% in August to 93.5% in September 2026 and remained red-rated against the dashboard threshold. This continues to indicate sustained pressure across inpatient services and the need for active patient-flow, discharge and escalation arrangements.	The organisation has escalation areas that are able to support when our bed occupancy is in a red status. Escalation areas are Ella, Level 2 AMU and the cohort bay in ED	To optimise flow with use of operations and flow teams. Areas to plan for discharge from the day of patient admission. SAFER to be an active tool to review discharges and plan for before lunch discharges. To meet the trust wide target of 33% of patients home for midday and 75% home pre 5pm. The discharge lounge to be utilised with all wards sending patients to this area to support flow.
Staffing Fill Rates	Days	RN / Midwives	Satisfactory	Compared with August 2026, inpatient registered nurse/midwife fill reduced on days from 90.8% to 89.7%, moving from green to amber, while night fill improved from 93.9% to 94.6% and remained green. Care staff fill reduced from 95.4% to 90.9% on days and from 110.8% to 108.1% on nights, with both remaining green. The daytime registered nurse/midwife reduction requires continued ward-level review through SafeCare and twice-daily staffing oversight.	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 involes new recruits employed by NHSP undertaking a 3 month training programme within our clinical areas to upskill so that at the end of the programme candidates will align to AFC band 3. To support fill rates the trainee programme will run with bi monthly to support filling the 3.1 FTE monthly net HCSW vacancies.	To apply the Safer Staffing SOP to ensure safecare is used to its potential to capture real time staffing and patients risks at the bedside. Review of the Enhanced care provision across the trust to support enhanced care and the unfill HCSW hours. Recruitment are working with clinical leads to support fragile services and areas where there are vacancies.
		Care Staff	Satisfactory			
	Nights	RN / Midwives	Satisfactory			
		Care Staff	Satisfactory			
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	Satisfactory	Overall CHPPD reduced from 4.2 to 4.0 on days and from 3.4 to 3.3 on nights between August and September 2026. Daytime registered nurse/midwife CHPPD remained 2.2, while care staff CHPPD reduced from 1.9 to 1.8. Night registered nurse/midwife CHPPD remained 1.8 and care staff CHPPD remained 1.6. Delivery remained broadly aligned to plan, although the daytime position should be reviewed alongside the reduction in registered nurse/midwife fill.	Review of CHPPD on a monthly basis. This data is shared nationally and inputted on Model hsopital for transparency. Where the fill rate is less then 90% and greater than 110% our senior nurse leaders are esked 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 comliance. To use the data to report trends and themes where complaince is outside of these metrics.
		Care Staff	Satisfactory			
		Overall	Satisfactory			
	Nights	RN / Midwives	Satisfactory			
		Care Staff	Satisfactory			
		Overall	Satisfactory			
HR Metrics	Sickness Rate		Limited	Inpatient sickness increased from 5.2% in August to 6.1% in September 2026 and remained red-rated. Turnover increased from 10.7% to 11.0% and remained green, while vacancy increased marginally from 8.1% to 8.2% and remained green. The deterioration in sickness requires continued absence-management and workforce oversight, with local triangulation against fill rates and temporary staffing demand.	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 unavailbilities 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 unavailbilities as part of our weekly senior leaders bank and agency meetings.
	Turnover Rate		Satisfactory			
	Vacancy Rate		Satisfactory			
Temporary Staffing	Prop. Bank Hours		Limited	Bank hours reduced from 6.15% in August to 5.50% in September 2026 and remained amber-rated. Agency hours remained very low and broadly unchanged at approximately 0.14%, retaining a green rating. This demonstrates continued control of agency use, while bank demand should remain under review alongside sickness, vacancy and staffing shortfalls.	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 priortise 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	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		Satisfactory			
Ward Accreditation			Limited	Ward accreditation continues to provide assurance on standards of care and improvement activity. Current outcomes should remain subject to local action-plan monitoring, Professional Standards oversight and peer learning, particularly for areas below silver accreditation.	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 contiinue to review the accreditiation document to ensure it remains current. To report outcomes and trends to the trust wide safety and quality group.
PATIENT SENSITIVE INDICATORS						
Safety	Red Flags	ETOC Red Flags	Limited	Inpatient staffing red flags increased substantially from 25 in August to 58 in September 2026. ETOC red flags increased from 3 to 17. The rise demonstrates increased reporting of real-time staffing and flow risks through SafeCare, but requires review of themes, affected shifts and mitigations through twice-daily staffing meetings and senior nursing governance.	To ensure staff are raising ETOC red flag to highlight where shift are not being filled. To ensure areas are being using red flags to capture real time risks for staff and patients. Red flags are discussed as part of the twice daily staffing meetings. Escalation to mitigate red flags can be seen in the Safer Staffing SOP.	To launch and embed OneDevon Safer Staffing SOP and embed across the ICO. For the ETOC lead nurse to work with senior leaders to ensure that ETOC red flags are being used to highlight risks across the organisation. There will be an updated learning package for staff to complete and be assessed as competent to use safe care alongside understanding the importance of using red flags.
		All Red Flags	Satisfactory			
	Mod. Harm Incs and Above		Satisfactory	Moderate harm incidents and above remained unchanged at 14 between August and September 2026. Although stable, the level requires continued triangulation with occupancy, staffing fill, acuity, sickness, vacancy and temporary staffing use, with themes reviewed through care group and trust-wide safety governance.	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 inidcate where patient demand is needed to reduce risks.
	Pressure Ulcers G2+ Acq. in Our Care		Satisfactory	There were no grade 2+ pressure ulcers acquired in our care in either August or September 2026, maintaining a positive and stable position. Preventative care, skin assessment, appropriate equipment and professional accountability should continue to support this outcome.	Review daily high risk areas at twice daily staffing meeting, redeploy staff in accordance to risk and patient dependency. To work with clinical governance to ensure learning is shared around incidents raised about pressre ulcers.	For senior leaders to follow the escalation process within the One Devon safer staffing SOP. Robust governance process and timely review of Datix and responses. Where harm has been caused AARs are completed. Trends across the directorate are reported to the Quality and Safety group.
	Falls	No Harm	Limited	No-harm falls reduced from 47 in August to 40 in September 2026, while falls with harm increased from 47 to 55. The reduction in no-harm falls is positive, but the increase in harmful falls requires focused review and triangulation with staffing, skill mix, dependency, enhanced-care requirements and local incident themes.	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 Qualiety 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 algining with guidance.
		Harm	Satisfactory			
	Medicine Errors		Satisfactory	Medicine errors reduced from 28 in August to 23 in September 2026. This is an improved position, although themes should continue to be reviewed alongside staffing levels, skill mix, temporary staffing use and supervision, with learning shared through care group and trust-wide quality and safety governance.	To ensure where temporary staff are used they are supported by the ward manager in their supervisory role. To track complaints and daitx reporting to improve learning on how staff can be supported. Approporiate staff skill mix is discussed at the daily staffiing meeting and where appropriate redeployed to spread risk across areas.	To review medicine error trends and themes as part of the trustwide sagety and quality group. For skill mix to be discussed daily at staffing meetings. For skill mix to be reviewed at 1st and 2nd approval. To work with NHS P to monitor complaints, themes and trends with temporary staffing.
	% Obs Completed on Time		Satisfactory	Observations completed on time remained unchanged at 91.5% from August to September 2026. Compliance remained above the 85% dashboard threshold and should continue to be monitored, with local follow-up where ward-level performance falls below expectation.	Data is reported monthly and sent to clinical leads for actions. Where complaince is below 85% this is managed within care directorates by the ADNPPs.	Monthly compliance reort to be sent to ADNPP and trends to be escalated via care groups.

Feedback	Patient Complaints		Satisfactory	Patient complaints increased from 2 in August to 4 in September 2026. Themes and learning should be reviewed alongside staffing, communication and patient-flow pressures, with actions monitored through care group governance.	Where harm is caused a full investigation is completed and reported on using the Datix platform. Timelines for complaint reponses are clear and where they can not be met this is escalated to the DCNO, PALS and patient, family member and or relative.	All complaints are reported on Datix. Trends and themes are discussed are the trustwide safety and quality group.
	FFT	% Pos. Resp.	Satisfactory	FFT positive-response and response-volume data were unavailable in both the August and September 2026 dashboard extracts. Clinical areas should continue to support accessible feedback capture and review response volumes and themes locally when data become available.	QR codes have been developed for all clinical areas to ensure that accessibility of providing feedback has improved. Where the patient group are unable to use QR codes volunteers have been used to support patients in completing feedback questionnaires. There is a monthly trust wide report so our senior leader can track the number of responses and work within their care group to improve upon this.	Report monthly on patient reponses themes and trends. To ensure areas who are not yet collecting data are supported by their ADNPP to begin the data collection process.
		No. of Resp.	Significant			

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) - September-2026

Torbay and South Devon NHS
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STAFFING METRICS				Emerg. Dept
Number of Attendances				7,380
Staffing Fill Rates	Days	RN / Midwives	(Aug-26)	97.0%
		Care Staff	(Aug-26)	85.0%
	Nights	RN / Midwives	(Aug-26)	91.5%
		Care Staff	(Aug-26)	64.1%
Actual Staffing Split	Days	% RN / Midwives Hours	(Aug-26)	65.1%
		% Care Staff Hours	(Aug-26)	34.9%
	Nights	% RN / Midwives Hours	(Aug-26)	70.0%
		% Care Staff Hours	(Aug-26)	30.0%
	Day / Night Split	% Day	(Aug-26)	53.3%
		% Night	(Aug-26)	46.7%
HR Metrics		Sickness Rate	(Jul-26)	8.4%
		Turnover Rate	(Aug-26)	13.4%
		Vacancy Rate	(Aug-26)	23.1%
Temporary Staffing		Prop. Bank Hours	(Aug-26)	5.3%
		Prop. Bank Hours	(Aug-26)	0.0%
Accreditation				#VALUE!

PATIENT SENSITIVE INDICATORS				Emerg. Dept
Number of Unplanned Reattendances				960
Service Delivery Times		% Waiting > 4 Hrs		40.4%
		% Waiting > 12 Hrs		12.2%
		Avg. Triage Time (mins)		23
		Ambulance Handovers < 30 mins	(Aug-26)	41.4%
Safety		All Red Flags		0
		Mod. Harm Incs and Above		4
		Medicine Errors		6
		PUs G2+ Acquired in Our Care		0
	Falls	No Harm		1
		Harm		2
	Sepsis	% Overall Sepsis 6 Compliance		100%
		% Antibiotics within 1 Hour		100%
Feedback		Patient Complaints		4
	FFT	% Positive Resp.	(Jul-25)	
		Number of Resp.	(Jul-25)	

Safer Staffing Dashboard - Emergency Care (ED Only) - September-2026 - Assurance

Torbay and South Devon NHS
NHS Foundation Trust

Measure	Assurance Summary1	Narrative	Mitigation	Actions

STAFFING METRICS						
Staffing Fill Rates	Days	RN / Midwives	limited	ED staffing fill rates were unchanged from August to September 2026. Registered nurse fill remained 97.0% on days and 91.5% on nights, both green-rated. Care staff fill remained 85.0% on days, amber-rated, and 64.1% on nights, red-rated. The sustained overnight care staff shortfall continues to require recruitment, bank utilisation, safe 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	limited			
	Nights	RN / Midwives	limited			
		Care Staff	limited			
HR Metrics		Sickness Rate	limited	ED sickness reduced from 10.0% in August to 8.4% in September 2026 but remained red-rated. Turnover increased from 12.7% to 13.4% and remained green under the dashboard threshold, while vacancy reduced from 24.5% to 23.1% but remained red-rated. The sickness and vacancy position continues to present a material risk to sustainable staffing and requires focused workforce oversight.	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	satisfactory			
		Vacancy Rate	limited			
Temporary Staffing		Prop. Bank Hours	limited	ED bank hours remained unchanged at 5.3% from August to September 2026, while agency use remained at 0.0%. Agency use therefore continued to be well controlled. Bank bookings should remain aligned to acuity, attendance patterns, skill mix and demand, with prioritisation of internal workforce options.	Maximise Bank Utilisation (Prop. Bank Hours) Prioritise fill through internal bank before agency usage Increase uptake via incentives and improved shift visibility Reduce Reliance on Agency Convert frequent agency shifts to bank bookings	Improve Workforce Flexibility Encourage cross-deployment of suitably skilled staff Expand flexible working options to increase bank participation Enhance Oversight and Monitoring Regular review of bank vs agency usage in ED
		Prop. Bank Hours	limited			
PATIENT SENSITIVE INDICATORS						
Number of Unplanned Reattendances				ED attendances reduced slightly from 7,403 in August to 7,380 in September 2026. Recorded unplanned reattendances also reduced from 989 to 960. The reduction is positive, although reattendance trends should continue to be reviewed alongside demand, streaming, senior clinical review, signposting and system-wide flow.	Strengthen Demand Management Implement streaming and triage models to redirect non-urgent attendances Promote use of alternative services (GP, UTCs, NHS 111)Improve Patient Flow Through ED Reduce delays in assessment, treatment, and discharge Work with site teams to improve timely admissions and bed	Strengthen Escalation and Oversight Activate escalation frameworks during high attendances Monitor real-time activity and respond quickly to pressures Promote Preventative and Community-Based Care Support initiatives that reduce avoidable ED attendances Improve access to urgent and same-day care pathways
Service Delivery Times		% Waiting > 4 Hrs	limited	ED flow performance improved on several measures from August to September 2026. The proportion waiting over 4 hours reduced from 51.3% to 40.4%, and the proportion waiting over 12 hours reduced from 13.5% to 12.2%. Average triage time improved from 24 to 23 minutes. Ambulance handovers completed within 30 minutes remained unchanged at 41.4%. All four measures remained red-rated, requiring continued use of escalation, surge and patient-flow arrangements.	THP 45 protocol now embedded to support this the Trust has a well practiced surge SOP. This support timely handover of patients , ensuring patients are off loaded from ambulances and care for in one of the Trusts escalated areas. Focused work is also underway looking at discharges and use of the discharge lounge to supportpatient flow.	To ensur robust use of the Surge SOP. To collect Trust data on discharge to understand blockers for discharges. To collect, reprt and review data trends for use of escalated areas.
		% Waiting > 12 Hrs	limited			
		Avg. Triage Time (mins)	limited			
		Ambulance Handovers < 30 mins	limited			
Safety		All Red Flags		ED safety indicators showed an improving but mixed position from August to September 2026. Moderate harm incidents and above reduced from 5 to 4, medicine errors reduced from 8 to 6 and no-harm falls reduced from 2 to 1; falls with harm remained at 2. There were no grade 2+ pressure ulcers acquired in care in either month. Sepsis 6 compliance improved from 92% to 100%, while antibiotics within one hour remained at 100%. Incidents and medicine errors should continue to be triangulated with staffing, acuity, crowding and demand.	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-	arly 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
		Mod. Harm Incs and Above	limited			
		Medicine Errors	limited			
		PUs G2+ Acquired in Our Care				
	Falls	Falls - No Harm	satisfactory			
		Falls - Harm	limited			
	Sepsis	% Overall Sepsis 6 Compliance	satisfactory			
		% Antibiotics within 1 Hour	satisfactory			
		Patient Complaints	limited	ED patient complaints increased from 0 in August to 4 in September 2026, moving from green to red. FFT positive-response and response-volume data remained unavailable. Complaint themes should be reviewed promptly alongside communication during waits, patient flow		Improve Communication: Ensure consistent, clear updates to patients on waiting times and care progress Respond Early to Concerns: Address issues in real time to prevent
		% Positive Resp.				

				and care experience, with visible learning and accessible feedback capture.	Improve patient feedback outcomes by focusing on clear communication, timely care, and patient-centred experience throughout the ED journey. Ensuring patients feel informed, respected, and updated—especially during long waits—will positively influence FFT responses and reduce complaints. Embedding structured feedback collection, rapid response to concerns, and visible learning from feedback will help build trust and drive continuous improvement.	escalation into formal complaints Enhance Patient Experience: Focus on dignity, privacy, and comfort across the ED journey Increase Feedback Capture: Make it easy and routine for patients to give FFT feedback (e.g. digital options, prompts at discharge) Promote Positive Interactions: Reinforce staff behaviours that support compassionate, patient-centred care Act on Feedback: Regularly review themes from complaints and FFT and implement visible improvements Close the Loop: Share “you said, we did” outcomes with staff and patients to build trust and engagement
Feedback	FFT	Number of Resp.				

1 Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.

Safer Staffing Dashboard - September-2026 - Notes and Definitions

Torbay and South Devon NHS
NHS Foundation Trust

STAFFING METRICS

Measure			Applicability	RAG Criteria			Notes and Definitions
				Red	Amber	Green	
Beds	Established Beds		Inpatient Only	*N/A*	*N/A*	*N/A*	Figures represent the established Bed Stock along with the percentage of available beds that were occupied throughout the month. 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.
	Bed Occupancy			>=93% or <77%	(>=77% and <80%) or (>90% and <93%)	>=80% and <=90%	
Number of Attendances			Emergency Only	*N/A*	*N/A*	*N/A*	The total number of ED attendances.
Staffing Fill Rates	Days	RN/Midwives	Inpatient and Emergency	<80%	>=80% and <90%	>=90%	Staffing Fill Rates represent the proportion of the planned staffing level that was met. A figure below 100% indicates that the actual staffing level was below the planned level; a figure above 100% indicates that the actual staffing level exceeded the planned.
		Care Staff					
	Nights	RN/Midwives					
		Care Staff					
Actual Staffing Split	Days	% RN / Midw.	Inpatient and Emergency	*N/A*	*N/A*	*N/A*	Figures represent the actual (rather than planned) split between Registered Nurses and Care Staff on day shifts and night shifts.
		% Care Staff Hours					
	Nights	% RN / Midw.					
		% Care Staff Hours					
	Day / Night Split	Day		*N/A*	*N/A*	*N/A*	Figures represent the actual (rather than planned) split between Day and Night for Registered Nurses and Care Staff combined.
		Night					
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	Inpatient Only	Actual CHPPD is <80% of the Planned CHPPD	Actual CHPPD is (>=80% and <90%) of the Planned CHPPD	Actual CHPPD is >=90% of the Planned CHPPD	Figures indicate the number of Care Hours per Patient resident on the ward at 23:59 each day. Figures for each staff category (and 'Overall') are split between the CHPPD provided by the Planned staffing level and the CHPPD provided by the Actual staffing level. The bracketed figures in the Actual column represent the difference between the Planned and the Actual figures with a positive difference indicating that the Actual CHPPD exceeds the Planned CHPPD. The RAG status is only applied to the Actual CHPPD column and is based on the relative difference between the Acutal CHPPD and the Planned CHPPD. A Green RAG status is assigned where there was no Planned staffing but Actual staffing was present.
		Care Staff					
		Overall Day					
	Nights	RN / Midwives					
		Care Staff					
		Overall Night					
HR Metrics	Sickness Rate		Inpatient and Emergency	>4%	>=3.65% and <=4%	<3.65%	Please note that the Vacancy Rate represents the difference between the Staff in Post FTE and the Establishment FTE - this means that if the Staff in Post FTE exceeds the Establishment FTE for a ward then a 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		Inpatient and Emergency	<5%	>=5 and	>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	>5%	
Accreditation			Inpatient and Emergency	*N/A*	*N/A*	*N/A*	Ward accreditation indicates national recognition of the general standard of care provided by a ward. There are five levels of accreditation: ○ **White: Below basic standards of care** ● **Bronze: Meets the basic standards expected for that area** ● **Silver: Meets all the standards expected for that area with a clear plan and evidence of improvement** ● **Gold: Meets all standards and is deemed excellent** ● **Platinum: Sustains Gold for a year** Maternity and Paediatrics assessments will begin in 2025 and there is no intention to begin assessments for the Intensive Care Unit. Please note that the indicators below the current status give the previous accreditation statuses held by the ward and not the accreditation statuses for the months prior to the current reporting month.

Safer Staffing Dashboard - September-2026 - Notes and Definitions (cont.)

Torbay and South Devon NHS
NHS Foundation Trust

PATIENT SENSITIVE INDICATORS

(Measures that are potentially impacted by staffing issues)

Measure			Applicability	RAG Criteria			Notes and Definitions
				Red	Amber	Green	
Number of Unplanned Reattendances			Emergency Only	*N/A*	*N/A*	*N/A*	
Service Delivery Times	% Waiting > 4 Hrs		Emergency Only	>5%	*N/A*	<=5%	The percentage of ED attendances that exceeded 4 hours.
	% Waiting > 12 Hrs			>0%	*N/A*	0%	The percentage of ED attendances that exceeded 12 hours.
	Avg. Triage Time (mins)			>=15	*N/A*	<15	The average time to triage (minutes).
	Amb. Handovers < 30 mins			<95%	*N/A*	>=95%	The percentage of Ambulance handovers completed within 30 minutes.
Safety	Red Flags Raised	ETOC Red Flags	Inpatient and Emergency (ETOC Red Flags: Inpatient Only)	>=2	1	0	A Red Flag is a concern raised by a member of staff regarding staffing levels. 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).
		All Red Flags		>=5	>=3 and <5	<3	
	Moderate Harm Incidents and Above		Inpatient and Emergency	>=3	>=1 and <3	=0	The number of incidents resulting in Moderate Harm where the ward / area was recorded as the location of the incident. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Grade 2+ Pressure Ulcers Acquired in Our Care		Inpatient and Emergency	>=4	>=2 and <4	<2	A Pressure Ulcer 'Acquired in Our Care' is a Pressure Ulcer that has developed subsequent to the Patient coming under our care. (This includes both those that are newly acquired and those that have resulted from a deterioration) The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Falls	No Harm	Inpatient and Emergency	>=3	>=1 and <3	=0	Figures represent the number of Patient falls where the location was recorded as the relevant ward. Figures are grouped by the month the incidents was recorded on Datix The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
		Harm		>=4	>=2 and <4	<2	
	Sepsis	% Overall Sepsis 6 Compliance	Emergency Only	<70%	>=70% and <90%	>=90%	The percentage of Patients meeting all six of the Sepsis 6 criteria. (They are: Sepsis proforma, Senior Review within an hour, Oxygen appropriately administered, IV access and bloods taken, Antibiotics administered appropriately, IV Fluids administered appropriately and Ongoing monitoring)
		% Antibiotics within 1 Hour		<70%	>=70% and <90%	>=90%	The percentage of appropriate Patients receiving antibiotics within one hour.
	Medicine Errors		Inpatient and Emergency	>=2	=1	=0	Figures represent the number of Patient medicine-related incidents where the location was recorded as the relevant ward. Figures are grouped by the month the incidents was recorded on Datix. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	% Obs Taken on Time		Inpatient Only	<80%	>=80% and <85%	>=85%	Figures represent observations taken on time as a percentage of those expected.

All measures sourced from Datix CloudIQ are grouped by the month that they were reported on the system which may not necessarily be the month that the incident occurred

Safer Staffing Dashboard - September-2026 - Notes and Definitions (cont.)

Torbay and South Devon NHS
NHS Foundation Trust

PATIENT SENSITIVE INDICATORS (cont.)

Measure		Applicability	RAG Criteria			Notes and Definitions
			Red	Amber	Green	
Feedback	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).
	FFT - % Positive Responses	Inpatient and Emergency	<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	Inpatient and Emergency	*N/A*	*N/A*	*N/A*	

Safer Staffing Dashboard - September-2026 - Notes and Definitions (cont.)

Torbay and South Devon NHS
NHS Foundation Trust

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 - September-2026 - Notes and Definitions (cont)

Torbay and South Devon NHS
NHS Foundation Trust

DATA SOURCES AND TIMINGS - STAFFING METRICS

Measure			From	When	Data Source Details
Beds	Established Beds		PAS / Rostering Team	2nd or 3rd working day of each month (PAS); by 15th of each month (Rostering Team)	Bed Occupancy igures 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.
	Bed Occupancy				
Number of Attendances			Tableau	2nd or 3rd working day of each month	Figures are taken from the 'UEC & System Flow Dashboard (E1110) - A&E Type 1 and 3 Summary' Tableau dashboard, filtered to display a monthly view.
Staffing Fill Rates	Days	RN/Midwives	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.
		Care Staff			
	Nights	RN/Midwives			
		Care Staff			
Actual Staffing Split	Days	% RN / Midw.			
		% Care Staff Hours			
	Nights	% RN / Midw.			
		% Care Staff Hours			
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives			
		Care Staff			
		Overall Day			
	Nights	RN / Midwives			
		Care Staff			
		Overall Night			
HR Metrics	Sickness Rate		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.
	Turnover Rate				
	Vacancy Rate				
Temporary Staffing	Prop. Bank 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.
	Prop. Agency Hours				
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 - September-2026 - Notes and Definitions (cont.)

Torbay and South Devon NHS
NHS Foundation Trust

DATA SOURCES AND TIMINGS - PATIENT SENSITIVE INDICATORS

(Measures that are potentially impacted by staffing issues)

Measure		From	When	Data Source Details
Number of Unplanned Reattendances		Symphony	2nd or 3rd working day of each month	Figures for this measure are obtained by running a query against warehoused Symphony data.
Service Delivery Times	% Waiting > 4 Hrs	Tableau and Symphony	2nd or 3rd working day of each month	Figures for the 4 hour breaches are taken from the 'UEC & System Flow Dashboard (E1110) - A&E Type 1 and 3 Summary' Tableau dashboard, filtered to display a monthly view. 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.
	% Waiting > 12 Hrs			
	Avg. Triage Time (mins)			

	Amb. Handovers < 30 mins				Figures for the Ambulance Handovers measure are taken from querying warehoused Symphony data.
Safety	Red Flags Raised	ETOC 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.
		All Red Flags			
	Mod. Harm Incs & Above		Datix CloudIQ Incident Module	2nd or 3rd working day of each month	Figures are taken from Datix CloudIQ and represent Unrejected incidents involving Patients. This is taken from the same incident data that is used by the QIG Dashboard. The 'Moderate Harm Incidents and Above' measure additionally filters for incidents with a Severity of Moderate, Severe or Death harms. The 'Grade 2+ Pressure Ulsers' measure additionally filters for incidents with a Category of Pressure Ulcer' along with a Subcategory indicating Grade 2, 3 or 4. The 'Falls' measures additionally filter for incidents with a Subcategory containing 'Slip, Trip or Fall' and split by Severity to distinguish between No Harm and Harm.
	Grade 2+ Pressure Ulcers Acquired in Our Care				
	Falls	No Harm			
		Harm			
	Sepsis	% Overall Sepsis 6 Compliance	Monthly Audit via a Formic Dashboard	5th day of each month	Figures are taken from the Sepsis Formic Dashboard with filters applied to only include figures applicable to ED for the reporting month.
		% Antibiotics within 1 Hour			
	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	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.
		Number of Responses			

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Financial Performance Report

Month 6

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NHS
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NHS Foundation Trust

Executive Summary

Key Financial Measures and Headlines

NHS
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 September 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- CIP delivery is on target with no variance to plan.
- Industrial Action Strike costs (£0.4m adverse),
- Income provision for activity lost due to EPR (£1.6m adverse)
- Undrawn ERF Reserve (£1.3m favourable)
- Other budget variances (£0.7m favourable) including significant overspends in ASC/CHC and Planned Care offset with other underspends and unallocated reserves.

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £6.4m relating predominantly to CIP and cost pressures on ASC/CHC operational budgets.
- Base case forecast suggests risk of £2.8m against planned ULP

Year to Date CIP position £0.0m variance to plan:

- CIP delivery YTD of £16.5m against a £16.5m target
- The percentage of schemes assessed as fully developed remains consistent with previous months c90% (£49m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£7.4m adverse) and with higher levels of delivery risk than previous months.

Workforce Update

- The Trust is reporting worked WTEs 49 below plan, contracted WTEs 20 above plan.
- Agency and bank spend are both above plan and national cap targets. Bank and agency usage spiked in Month 5, reflecting increasing demand in peak leave periods and has reduced in Month 6.

Plan	YTD / Forecast	Measure	Month 06 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	(6.4)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(2.8)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	0.0
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(7.4)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	0.7
Cash Plan	YTD	Unplanned Cash Support	0.0
Cash Plan	Forecast	Unplanned Cash Support	0.0

Capital programme update:

- Year to date capital plan is underspent (£0.7m)
- Forecast to deliver up to capital limits, £2.7m above initial plan, including additional allocation of £2.2m National PDC and £0.5m increase to CDEL allocation.

Cash Update:

- The Trust closing cash balance for Month 6 was (£15.1m) below plan, due to not drawing £10.193m PDC Revenue Support (per the plan to M06), with remaining £4.9m shortfall related to a receipt of £6.2m from Torbay Council after the ledger close.
- The Trust has submitted an application for £10.193m PDC Revenue Cash Support in M07 for drawdown in M08 with the expectation to repay in full in M12, reflecting the agreed 2026/27 plan.

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

NHS
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 6 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 September shows a month end position of **£10.2m** deficit, as planned. The position excluding DSF is **£39.1m** deficit at the end of September, 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), a provision against contract income was made to recognise activity lost through EPR implementation (£1.6m adverse to plan), with a favourable variance on undrawn ERF reserve (£1.3m favourable). All other corporate and frontline budgetary variances totalled £2.2m adverse to plan, with £2.9m other favourable variances from undrawn reserves.

EPR implementation 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£1.6m in the position. 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 submitted a Mid-Year forecast to NHSE confirming full commitment to plan delivery and including mitigations and recovery actions to secure this position. The Trust's month 6 forecast is consistent with this forecast as a best case forecast, but reflecting a gap to full plan delivery of £1.6m where the ASC/CHC position has deteriorated further and requires additional, not yet identified mitigation. The base case forecast recognises forecast risks to delivery of **£6.4m**, with up to **£14.9m** in the downside risk assessment (with £2.8m risk to the ULP in the base case and £12.7m 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 identify further mitigations to deliver the plan.

Year to date at Month 6 the Trust has recognised CIP delivery of **£16.5m** against a **£16.5m** target (**£0.0m** variance to plan). Since the plan was submitted intensive work is continuing to be undertaken on implementing the CIP plans. Fully developed plans have increased by £0.2m however, from a risk perspective, there has been a £2.2m increase in high level risk and a £3.2m increase in medium risk which demonstrates some of the emerging risks. The Trust is still forecasting full delivery of the £54.4m target.

The Trust is reporting a cash balance of **£3.2m** as at 30th September 2026, **£15.1m lower** than planned, primarily due to not drawing **£10.193m** PDC Revenue Support (per the plan to M06), with the remaining **£4.9m** shortfall primarily related to a receipt of **£6.2m** from Torbay Council after the ledger close. The Trust has now submitted an application for **£10.193m** PDC Revenue Cash Support in M07 for drawdown in M08 with the expectation to repay in full in M12, reflecting the agreed 2026/27 cash plan.

At Month 6 the Trust has spent **£8.5m** of capital compared to plan of **£9.3m**, an underspend of **£0.7m**. The Trust is forecasting to spend up to capital limits, including an additional £2.2m National PDC Capital including Tower Safety and SDEC schemes and an additional £0.5m adjustment to CDEL allocation adjustment.

The Finance and Operations 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.

The Finance and Operations Committee is requested to note the requirement for temporary cash support and **APPROVE** the request for £10.193k of Revenue PDC Support, as planned.

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NHS Foundation Trust

Finance Plan Delivery - Revenue

Financial Position

Torbay and South Devon NHS Foundation Trust

Care Groups	In Month			YTD			Forecast Outturn			YTD Variance					
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Total	Income	Pay	Non-Pay	Passthrough	CIP
	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Families & Communities	(7.5)	(8.4)	(0.9)	(43.4)	(45.1)	(1.7)	(81.3)	(89.3)	(8.0)	(1.7)	0.4	(0.2)	(1.4)	0.0	(0.5)
Medicine and Urgent Care	(7.7)	(7.3)	0.4	(48.1)	(47.7)	0.4	(93.2)	(96.3)	(3.1)	0.4	0.2	(0.1)	0.2	0.0	0.0
Planned Care and Surgery	(12.7)	(13.1)	(0.3)	(78.1)	(80.9)	(2.8)	(149.7)	(157.4)	(7.6)	(2.8)	0.6	(1.6)	(0.8)	(0.0)	(1.1)
Adult Social Care – Torbay	(2.2)	(2.8)	(0.6)	(14.3)	(16.3)	(2.0)	(24.7)	(31.9)	(7.2)	(2.0)	0.0	0.0	(0.4)	0.0	(1.6)
Total Frontline Services	(30.1)	(31.6)	(1.5)	(183.9)	(190.0)	(6.1)	(348.9)	(374.8)	(25.9)	(6.1)	1.3	(1.8)	(2.4)	(0.0)	(3.1)
Corporate	(4.9)	(4.8)	0.1	(31.7)	(29.6)	2.1	(63.3)	(60.6)	2.7	2.1	0.9	0.1	(0.4)	0.0	1.5
Workplace (Estates)	(2.4)	(2.8)	(0.3)	(14.8)	(15.6)	(0.9)	(29.2)	(31.8)	(2.6)	(0.9)	0.1	0.3	(0.6)	0.0	(0.7)
Total Professional Support Services	(7.3)	(7.5)	(0.2)	(46.4)	(45.2)	1.2	(92.5)	(92.4)	0.1	1.2	1.0	0.4	(0.9)	0.0	0.8
Healthcare Contract Income	36.5	36.8	0.2	215.7	213.8	(1.9)	433.4	435.2	1.8	(1.9)	(1.8)	0.0	0.0	(0.0)	(0.1)
Reserves	(2.0)	(0.4)	1.5	(9.4)	(2.8)	6.6	(18.9)	4.9	23.9	6.4	(2.9)	2.3	4.7	(0.1)	2.5
Prior Periods	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.4	0.0	(0.3)	0.0	0.0
Other Trust Budgets	(2.6)	(2.6)	(0.0)	(15.1)	(14.9)	0.2	(30.8)	(30.7)	0.2	0.2	0.7	(0.0)	(0.4)	0.0	(0.0)
Other Budgets	32.0	33.7	1.7	191.2	196.1	4.9	383.6	409.4	25.8	4.9	(3.6)	2.3	4.0	(0.1)	2.3
Total Excluding Deficit Support Funding (DSF)	(5.5)	(5.5)	(0.0)	(39.1)	(39.1)	(0.0)	(57.8)	(57.8)	(0.0)	(0.0)	(1.4)	0.8	0.6	(0.1)	0.0
Deficit Support Funding (DSF)	4.8	4.8	0.0	28.9	28.9	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)	(0.6)	(0.6)	(0.0)	(10.2)	(10.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(1.4)	0.8	0.6	(0.1)	0.0

The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between **£6.4m** in the base case and up to **£14.9m** in the downside risk assessment, with risk to the recurrent underlying position of £2.8m (base case) and £12.7m (downside risk assessment). The Trust will continue to work with operational leads, NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and identify further mitigations.

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

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 September shows a month end position of **£10.2m** deficit, as planned. The position excluding DSF is **£39.1m** deficit at the end of September, as planned.

The Trust was on plan overall, but with the following significant variances noted within this balanced position:

- CIP delivery on plan
- Industrial Action costs (£0.4m adverse),
- Income provision for activity lost due to EPR implementation (£1.6m adverse)
- Undrawn ERF reserve (£1.3m favourable)
- Favourable variances on trustwide budgets mainly due to other unallocated reserves (£2.9m)
- Other frontline and corporate operational budgets are overspent in total (£2.2m adverse). Of these variances the ASC/CHC overspend (£1.5m adverse) is of particular concern as this includes a Non-recurrent accrual release from 2025-26 of £1.0m offsetting an in year overspend of £2.5m, relating to very high cost packages of care.

Forecast Risks and Mitigations - Summary

Torbay and South Devon NHS Foundation Trust

Category	Detail	Month 6 YTD	Forecast Outturn				
			Downside Risk	Difference Worst to Base Case	Base Case	Difference Best to Base Case	Upside Risk
		(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations
		£M	£M	£M	£M	£M	£M
Plan		**(10.2)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CIP	**CIP Net Risk**	**0.0**	**(9.6)**	**(5.5)**	**(4.1)**	**4.1**	**0.0**
Elective Recovery	**EPR implementation impact**	**(0.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Other Plan Variances	**Other Plan Variances**	**0.3**	**(4.3)**	**(2.0)**	**(2.3)**	**0.7**	**(1.6)**
Inflationary Pressures	**Inflationary Pressures**	**0.0**	**(1.0)**	**(1.0)**	**0.0**	**0.0**	**0.0**
Net Risks and Mitigations	**Net Risks and Mitigations**	**(0.0)**	**(14.9)**	**(8.5)**	**(6.4)**	**4.8**	**(1.6)**
Unidentified Mitigations	Unidentified Mitigations	0.0	14.9	8.5	6.4	(4.8)	1.6
High Risk Mitigations	**High Risk Mitigations**	**0.0**	**14.9**	**8.5**	**6.4**	**(4.8)**	**1.6**
Plan Net Risk to Forecast	**Plan Net Risk to Forecast**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Outturn	**Outturn**	**(10.2)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	Net Non-Recurrent (Risk)/ Mitigation	5.4	16.4	6.2	10.2	(2.8)	7.4
	Net Recurrent (Risk)/ Mitigation	(5.4)	(16.4)	(6.2)	(10.2)	2.8	(7.4)
	FYE Recurrent CIP	0.0	3.7	(3.7)	7.4	0.0	7.4
Plan Underlying Deficit	**Plan Underlying Deficit**		**(65.0)**	**0.0**	**(65.0)**	**0.0**	**(65.0)**
Forecast Recurrent Risk	Total Trust ULP Risk	(5.4)	(12.7)	(9.9)	(2.8)	2.8	0.0
Forecast Underlying Deficit	**Forecast Underlying Deficit**		**(77.7)**	**(9.9)**	**(67.8)**	**2.8**	**(65.0)**

The Trust is forecasting achievement of the breakeven revenue plan but recognises forecast risks to delivery of between £1.6m and £14.9m in the best and worst likely cases, with a base case estimate of £6.4m.

The most significant risk is CIP delivery. Significant additional mitigations have been brought into the forecast reflecting planned elective and UEC recovery as well as other recovery actions to secure plan delivery. The best case includes risk assessed delivery on all CIP schemes in progress as well as new recovery plans. The base case risk assesses all schemes not yet at full delivery at 25% (opportunity) and 75% (plans fully developed, not yet delivering) to arrive at a CIP risk of £4.1m.

The next most significant risk is the costs of Adult Social Care and Continuing Healthcare, where at month 6, an overspend of £1.5m has been incurred, with a £1.0m favourable impact from 2025-26 is offsetting a £2.5m year to date overspend. In the base case, a continuation at run rate results in between £6.6m and £5.1m overspend, partially mitigated in year by slippage in commitment of reserves.

The risks to ULP are estimated between £12.7m and £0.0m, with £2.8m in the base case.

Further details of risks on the following slides.

Action: Continue bi-monthly FDG meetings to maintain focus on accelerating plans through maturity and into delivery and resolve other emergent risks.

Action: Work with Performance and Ops teams to forecast impact of data corrections, productivity improvements and proposed additional capacity on contract delivery.

Action: Assess all available options to close the forecast risk gap and deliver financial plan, including 'unpalatable' and high risk options.

Forecast Risks and Mitigations - Detail

NHS
Torbay and South Devon
NHS Foundation Trust

Category	Detail	Recurrent/ Non-Recurrent	Month 6 YTD	Forecast Outturn				
				Downside Risk	Difference Worst to Base Case	Base Case	Difference Best to Base Case	Upside Risk
			(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations
			£M	£M	£M	£M	£M	£M
Plan			**(10.2)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CIP	Delivery Risk	NR	0.0	(1.6)	(0.3)	(1.3)	1.3	0.0
CIP	Delivery Risk	R	0.0	(8.0)	(5.2)	(2.8)	2.8	0.0
CIP	In Year slippage on recurrent schemes	R	(5.4)	(7.4)	0.0	(7.4)	0.0	(7.4)
CIP	Delivery on Non-Recurrent Schemes	NR	5.4	7.4	0.0	7.4	0.0	7.4
CIP	**CIP Net Risk**		**0.0**	**(9.6)**	**(5.5)**	**(4.1)**	**4.1**	**0.0**
Elective Recovery	Capped ERF Delivery	NR	0.0	0.0	0.0	0.0	0.0	0.0
Elective Recovery	Loss of Activity due to EPR Implementation	NR	(1.6)	(0.3)	0.0	(0.3)	0.0	(0.3)
Elective Recovery	Recovery of Activity within Financial Envelope	NR	0.0	0.3	0.0	0.3	0.0	0.3
Elective Recovery	Underspend on ERF Reserve	NR	1.3	0.0	0.0	0.0	0.0	0.0
Elective Recovery	**EPR implementation impact**		**(0.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Other Plan Variances	Industrial Action - Costs	NR	(0.4)	(0.4)	0.0	(0.4)	0.0	(0.4)
Other Plan Variances	Industrial Action - Funding	NR	0.0	0.0	0.0	0.0	0.0	0.0
Other Plan Variances	Balancesheet Flexibility	NR	0.4	0.4	0.0	0.4	0.0	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	2.0	0.0	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	(2.0)	(7.6)	(1.5)	(6.1)	0.6	(5.5)
Other Plan Variances	ASC/PP gain from 2025-26	NR	1.0	1.0	0.0	1.0	0.0	1.0
Other Plan Variances	Slippage on other growth and inflation reserves	NR	3.0	4.5	0.0	4.5	0.0	4.5
Other Plan Variances	Other Operational Budget net Overspends	NR	(1.7)	(1.7)	0.0	(1.7)	0.1	(1.6)
Other Plan Variances	**Other Plan Variances**		**0.3**	**(4.3)**	**(2.0)**	**(2.3)**	**0.7**	**(1.6)**
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
Inflationary Pressures	**Inflationary Pressures**		**0.0**	**(1.0)**	**(1.0)**	**0.0**	**0.0**	**0.0**
Net Risks and Mitigations			**(0.0)**	**(14.9)**	**(8.5)**	**(6.4)**	**4.8**	**(1.6)**
Unidentified Mitigations	Unidentified Mitigations	NR	0.0	14.9	8.5	6.4	(4.8)	1.6
High Risk Mitigations			**0.0**	**14.9**	**8.5**	**6.4**	**(4.8)**	**1.6**
Plan Net Risk to Forecast			**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Outturn			**(10.2)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	Net Non-Recurrent (Risk)/ Mitigation	NR	5.4	16.4	6.2	10.2	(2.8)	7.4
	Net Recurrent (Risk)/ Mitigation	R	(5.4)	(16.4)	(6.2)	(10.2)	2.8	(7.4)
	FYE Recurrent CIP	R	0.0	3.7	(3.7)	7.4	0.0	7.4
Plan Underlying Deficit				**(65.0)**	**0.0**	**(65.0)**	**0.0**	**(65.0)**
Forecast Recurrent Risk	Total Trust ULP Risk	R	(5.4)	(12.7)	(9.9)	(2.8)	2.8	0.0
Forecast Underlying Deficit				**(77.7)**	**(9.9)**	**(67.8)**	**2.8**	**(65.0)**

Net CIP Risk (base assumption £4.1m adv): The Trust has refreshed CIP delivery in light of H2 review, taking account of recovery and control measures such as vacancy freeze, holding reserves etc. Delivery risks, particularly on shortfall of ASC/CHC targets (£5.0m) and UEC bed pressures (£1.3m) have been mitigated with additional measures to support full CIP delivery in the best case but recognising £4.1m risk on lower maturity schemes in the base case (and £9.6m in the downside assessment).

Elective Recovery Risk – EPR implementation (base assumption £0.0m adv): Year to date the provision recognised on ERF income is £1.6m. There is an undrawn ERF reserve balance of £1.3m year to date. Latest trajectories indicate that the activity lost due to implementation will be recovered due to favourable changes in casemix, where coding depth in EPR is increasing the tariff per unit of activity. The base forecast for Elective delivery assumes overperformance on the contract, paid at full tariff, not 50% marginal tariff, due to other provider underperformance. CIP delivery assessment has been updated on this basis.

Other Plan Variances (base assumption £2.3m adv): There are a variety of under and overspends on other operational budgets, the most significant of which is in ASC and CHC, which is likely to overspend by c£5.1m, partially offset by other budgetary underspends.

Inflationary Pressures (base assumption £0.0m adv): The impact of the nurse band 5 review process is assumed to be delivered within he £1.0m funding available in the base case, but a potential downside of £1.0m may materialise.

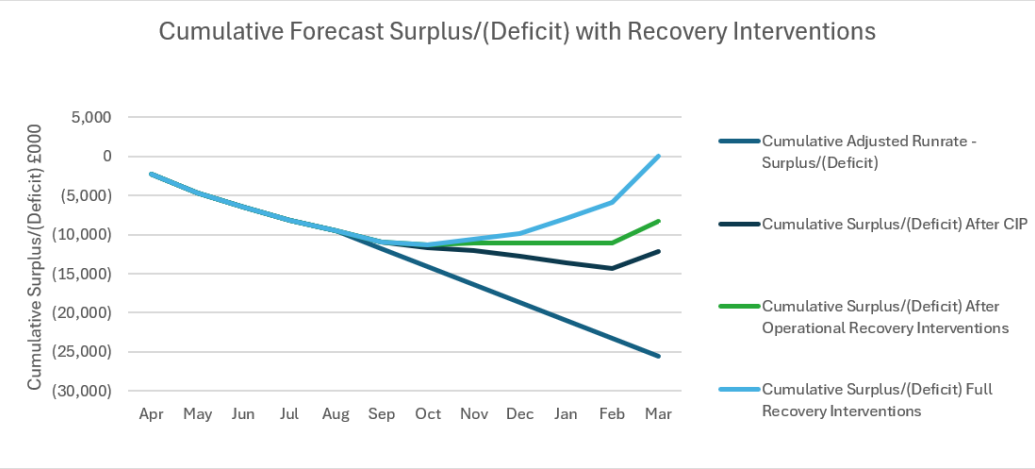
Deficit Support Funding (base assumption £0.0m adv): The Trust is forecasting on plan delivery, therefore no loss of DSF has been forecast, however it should be noted that NHSE have briefed that DSF will be withdrawn to the extent that the Trust does not deliver financial performance.

Mid-Year Review Forecast and Recovery

NHS
Torbay and South Devon
NHS Foundation Trust

Mid-Year Review:

- As part of the Mid-Year Review TSD was required to submit a H2 forecast and letter committing to plan delivery. A non-breakeven forecast, or a breakeven forecast which NHSE did not consider robust and deliverable would result in national escalation and a formal leadership review.
- The Trust submitted a forecast to breakeven, including some significant and difficult recovery actions to support delivery. This was accepted by NHSE and the Trust has not had DSF withdrawn or gone into national escalation.
- The Trust will now need to move into full implementation very quickly to ensure that Trust recovery actions deliver the forecast.
- Summary of trajectory below, with summary of decisions on following slide, full runrate reconciliation submission in Appendix 1.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2026-27
Actual Surplus/(Deficit)	(2,306)	(2,385)	(1,813)	(1,704)	(1,345)								(9,553)
Runrate (M1-5 Pro-Rata)						(1,911)	(1,911)	(1,911)	(1,911)	(1,911)	(1,911)	(1,911)	(13,374)
Adjustments to Runrate for Non-recurrent Transactions in YTD						(377)	(377)	(377)	(377)	(377)	(377)	(377)	(2,640)
Adjusted Runrate - Surplus/(Deficit)	**(2,306)**	**(2,385)**	**(1,813)**	**(1,704)**	**(1,345)**	**(2,288)**	**(2,288)**	**(2,288)**	**(2,288)**	**(2,288)**	**(2,288)**	**(2,288)**	**(25,568)**
Risk Adjusted CIP delivery						882	1,432	1,745	1,395	1,395	1,395	4,239	12,485
Other low risk changes expected						57	57	157	157	157	157	157	900
Surplus/(Deficit) After CIP	**(2,306)**	**(2,385)**	**(1,813)**	**(1,704)**	**(1,345)**	**(1,348)**	**(799)**	**(385)**	**(735)**	**(735)**	**(735)**	**2,109**	**(12,182)**
Elective/RTT Recovery						0	350	650	750	750	750	764	4,014
UEC Recovery						0	0	0	0	0	0	0	0
Other Investments						0	0	0	0	(44)	(44)	(44)	(132)
Surplus/(Deficit) After Operational Recovery Interventions	**(2,306)**	**(2,385)**	**(1,813)**	**(1,704)**	**(1,345)**	**(1,348)**	**(449)**	**265**	**15**	**(29)**	**(29)**	**2,829**	**(8,300)**
Technical Solutions (Moderate Risk)						0	0	0	0	1,333	1,333	1,833	4,500
Workforce Controls						0	89	180	287	344	450	557	1,908
Commercial Income Generation						0	0	50	50	50	50	50	250
Non-Pay Controls						0	0	158	407	241	241	597	1,643
Surplus/(Deficit) Full Recovery Interventions	**(2,306)**	**(2,385)**	**(1,813)**	**(1,704)**	**(1,345)**	**(1,348)**	**(360)**	**653**	**758**	**1,939**	**2,045**	**5,866**	**0**

Mid-Year Review Forecast and Recovery

Torbay and South Devon NHS Foundation Trust

Recovery Actions

The focus of the recovery actions agreed is cost reduction, but not at the expense of patient safety or ability to deliver operational performance.

We recognise that some of these measures are not sustainable and are targeted towards delivering the plan this financial year, but real productivity improvements must be embedded to meet our next year ULP.

A summary of key decisions is set out below, a full assessment of the opportunities considered in the 'Plan B' list and '10 Point Plan' provided by the ICB are included in the information pack (Appendix 2 and 3).

- **Vacancy Freeze –** no external recruitment unless an approved patient-safety exception applies (and for agreed ERF and UEC investments).
- **Reduced Premium Cost Activity** - No booking of insourced, outsourced or WLI activity without prior approval.
- **Reduce premium staff costs** – reduce bank rates, end to bank, agency and overtime arrangements not essential to patient safety or operational delivery.
- **Reduce discretionary non-pay** – targeted reduction target will be notified to all budget holders with monitoring and escalation through QPAG
- **Defer new investment** – any new investments approved will be for implementation in 2027-28.
- **Productivity** – Additional new outpatient to be added to every outpatient clinic, deliver improvements identified in specialty productivity plans.
- **UEC recovery** – only UTC/SDEC/Frailty investments will be funded from non-variable growth. Investment will be within monthly reserve value.
- **Escalation bed costs –** the UEC investments will result in cost reduction at least equal to investment by reducing escalation bed costs.
- **Commercial Income** – Trust will review all sources of commercial income with a view to increasing prices, including charges to staff on car parking and catering, but aiming to minimise impact of lowest paid staff.
- **Technical/NR** – the Trust will complete full review of all flexibility, to include release of deferred income.
- **Weekly Reporting** – the Trust will move to a weekly reporting regime aligned to System/NHSE expectations.

Forecast Bridge to Runrate

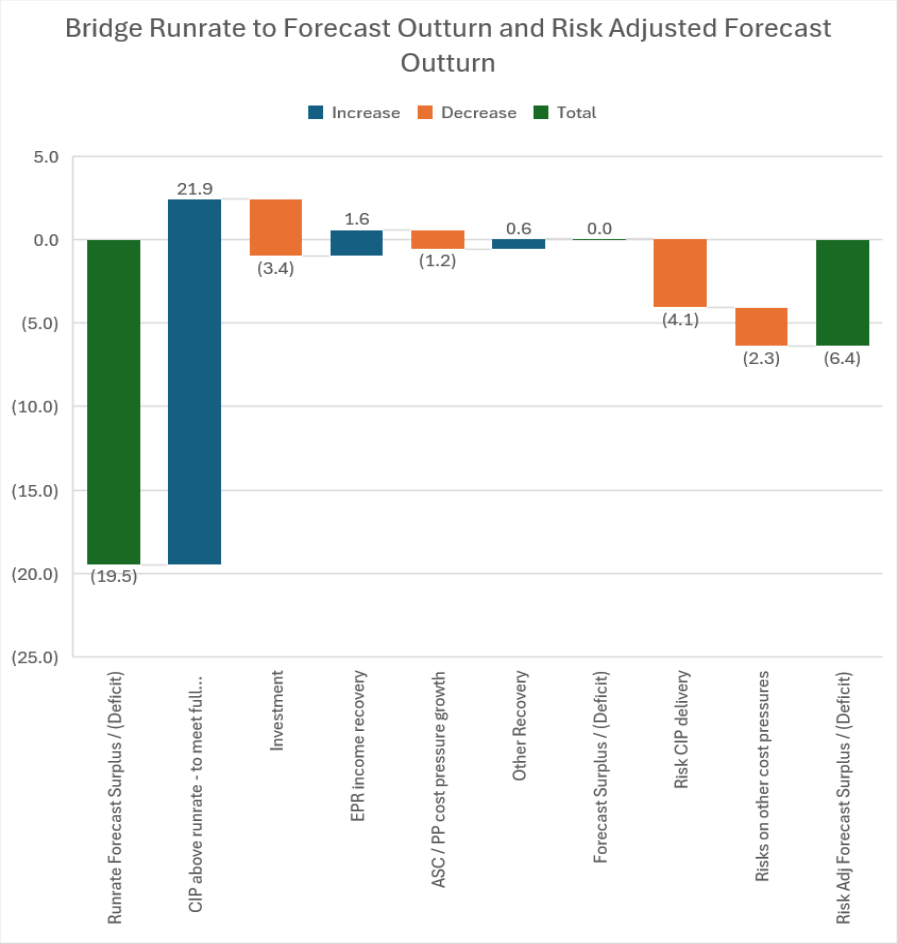
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Year to Date to Forecast Bridge	£M
YTD Surplus/(Deficit)	**(10.2)**
Adjust non-recurrent Industrial Action - Costs	0.4
Adjust non-Recurrent Provision for EPR lost activity	1.6
Adjust other non-recurrent transactions	(1.1)
Recurrent YTD Surplus/(Deficit)	**(9.3)**
Recurrent Monthly Runrate	(1.5)
Recurrent runrate (M7-12)	(9.3)
Runrate Forecast Surplus / (Deficit)	**(19.5)**
CIP above runrate - to meet full target	21.9
Investment	(3.4)
EPR income recovery	1.6
ASC / PP cost pressure growth	(1.2)
Other Recovery	0.6
Forecast Surplus / (Deficit)	**0.0**
Risk CIP delivery	(4.1)
Risks on other cost pressures	(2.3)
Risk Adj Forecast Surplus / (Deficit)	**(6.4)**

The Trust's reported forecast for Month 6 reflects an expectation of full plan delivery.

This forecast requires run rate improvements of £3.2m per month in order to deliver a breakeven outturn, as well as restoration of lost activity.

Aligned to base case risks the Trust recognises £6.4m of risk in this trajectory.

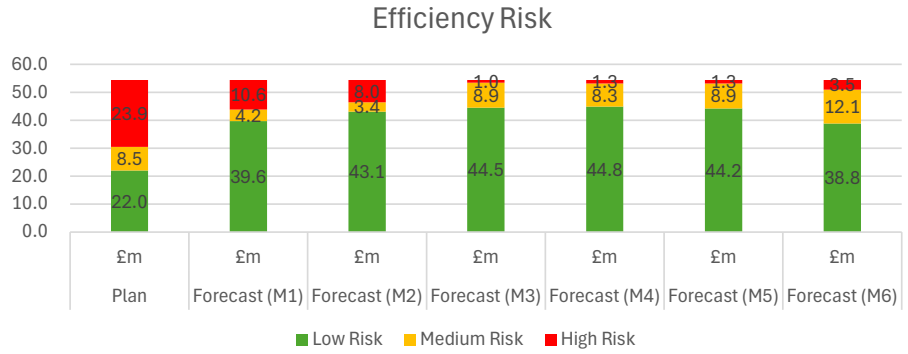


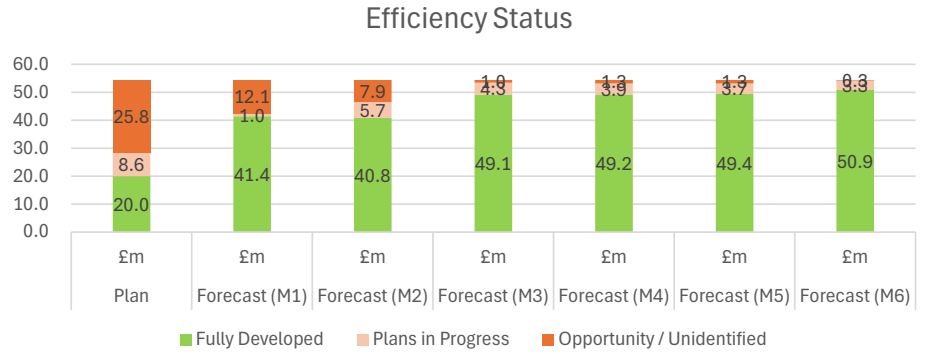
Efficiencies – Maturity and Risk

Torbay and South Devon NHS Foundation Trust

	M6			Forecast Outturn		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/(-) £m	Plan for the year £m	Forecast £m	Var +/(-) £m
Recurrent efficiencies	15.2	9.8	(5.4)	43.4	36.0	(7.4)
Non-recurrent efficiencies	1.3	6.7	5.4	11.0	18.4	7.4
Total	**16.5**	**16.5**	**0.0**	**54.4**	**54.4**	**0.0**
Recurrent %	92%	60%		80%	66%	
Non-recurrent %	8%	40%		20%	34%	

Year to date, the Trust has fully delivered savings against a £16.5m target, though this has been heavily supported with non-recurrent savings. The Trust is forecasting full delivery of the £54.4m target.





Whilst still over 90% of plans remain fully developed, there has been a material deterioration in the assessed delivery risk and circa 6% is currently assessed High risk and 23% Medium risk. This reflects the risks particularly around ASC, and recovery plans that have been developed to compensate for delayed implementation of schemes, with **limited assurance** around delivering the full efficiency requirement.

Workforce Position

NHS
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	4
Pay - substantive	(181.8)	(179.8)	1.9	(359.3)	(356.5)	2.8	6,044	5,916	128
Pay - bank	(8.7)	(10.5)	(1.8)	(17.0)	(17.9)	(0.9)	259	324	(65)
Pay - agency	(2.1)	(2.6)	(0.5)	(4.1)	(5.3)	(1.2)	36	53	(17)
Grand Total	**(192.6)**	**(193.0)**	**(0.4)**	**(380.6)**	**(379.9)**	**0.7**	**6,344**	**6,295**	**49**

The Trust ledger at month 6 reflects a **worked** variance to plan that is **49 WTEs below plan** (6,344 in plan and 6,295 actuals).

The Trust workforce return for month 6 is reporting a **contracted** variance to plan of 20 **WTEs above plan** (6,344 in plan and 6,365 actuals).

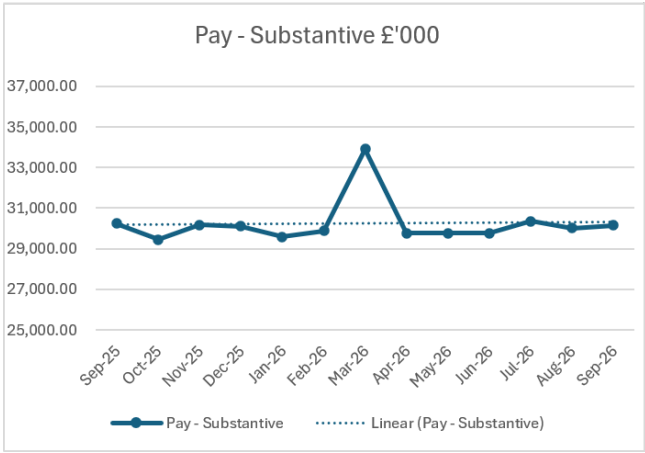
Worked WTEs are 69 lower than contracted WTEs due to overtime, maternity and sickness absence.

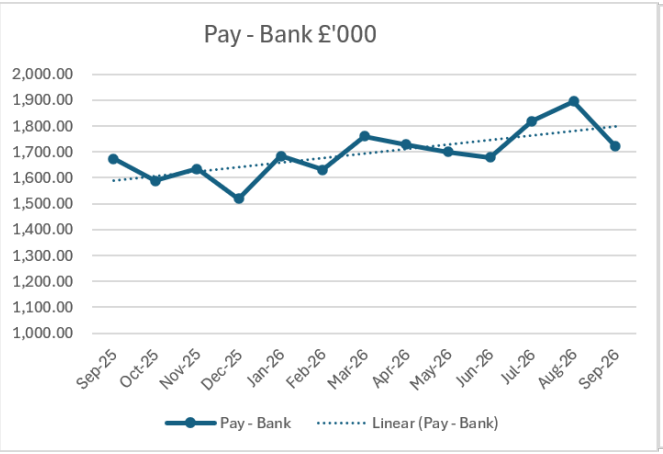
Of the 49 WTEs lower than plan, there are 99 WTEs below plan associated with unspent reserves, 93 WTEs over plan across frontline delivery budgets and 43 WTE below plan in corporate services (including EFM).

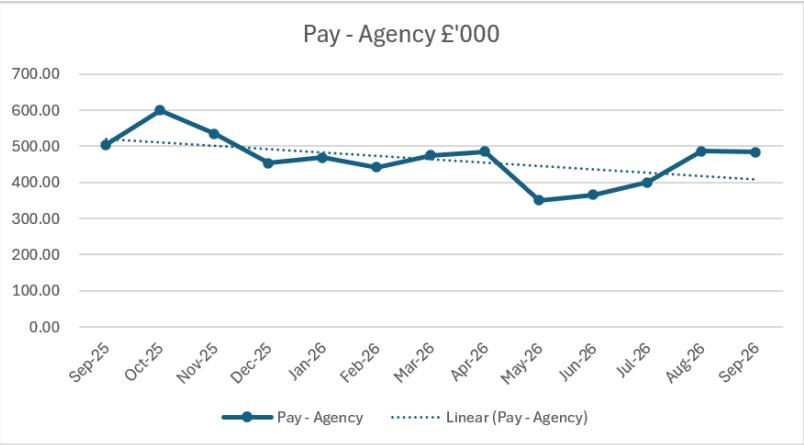
Plan WTE	Actual WTE	Variance WTE	Narrative
6,050	5,987	(63)	ESR Reported contracted WTE 30th September 2026
36	53	17	Agency
259	324	65	Bank
6,344	**6,365**	**20**	**Subtotal**
0	86	86	Overtime and additional hours
0	(113)	(113)	Maternity and adoption leave
0	(42)	(42)	Sickness
0	**(69)**	**(69)**	**Total reported worked WTEs 30th September 2026**
6,344	**6,295**	**(49)**	**Worked WTEs**

Workforce Trend

NHS
Torbay and South Devon
NHS Foundation Trust

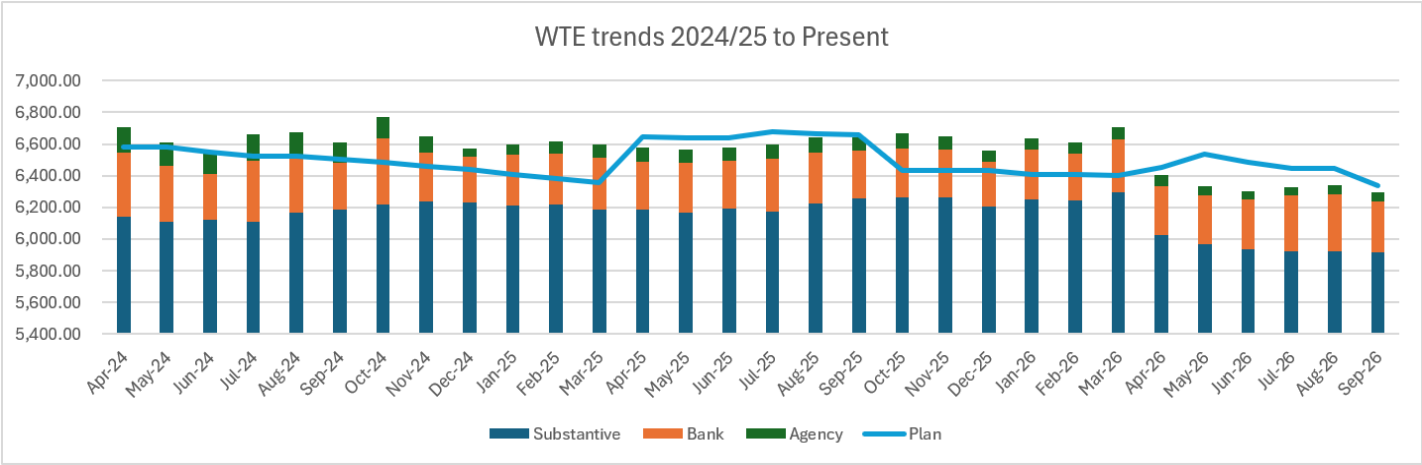






Temporary pay costs spiked in Month 5, consistent with summer periods in previous years, but have reduced in Month 6.

Worked WTEs are significantly lower than 2025-26 averages due to transfer of CFHD.



Contract Activity & Income

NHS
Torbay and South Devon
NHS Foundation Trust

Elective Recovery Funding (ERF) – Variance to Contract: At M6 the Trust recognised a provision for ERF activity below contract of £1.6m. Subsequent analysis of earnings to contract value suggests that the Trust may be overperforming by c£0.2m. The table to the right reflects the Trust's estimated earnings compared to contract value on a straight line basis (YTD contract value is presented as 6/12ths of full year value).

Is ERF	Data Type	Setting	Attendance Type	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 £
Yes	APC	Day Case & RD	Spell	15,291	14,907,689	15,972	17,337,812	16,478	17,294,902	506	-42,910
		Elective	Spell	1,303	6,043,996	979	6,639,557	1,198	6,447,017	220	-192,540
	APC Total			16,593	20,951,685	16,951	23,977,369	17,676	23,741,920	725	-235,449
	OPA	First	Attendance	40,840	9,266,928	41,685	9,458,884	40,209	9,606,874	-1,476	147,991
			Procedure	13,859	2,840,896	13,859	2,840,896	13,812	2,581,709	-47	-259,187
		Follow-up	Procedure	33,523	7,484,608	35,975	7,129,440	36,154	7,660,989	179	531,549
	OPA Total			88,222	19,592,432	91,519	19,429,220	90,175	19,849,572	-1,344	420,353
Yes Total				104,815	40,544,117	108,470	43,406,588	107,851	43,591,492	-618	184,903
Grand Total				104,815	40,544,117	108,470	43,406,588	107,851	43,591,492	-618	184,903

Elective Recovery Funding (ERF) – Variance to Activity Plan: The Trust resubmitted an operating plan in July which transferred recovery of lost Q1/Q2 outpatient, day-case and elective underperformance into the second half of the year and shifted expectations of backlog RTT recovery to non-admitted waiting list activity to minimise risk of breaching ICB ERF envelope. The table below compares this revised plan submission with YTD activity and earnings. Although this reflects overperformance of £3.0m YTD it is important to note that achieving the rephased plan will require a significant increase in M7-12 activity compared with delivery to date.

Is ERF	Data Type	Setting	Attendance Type	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 £
Yes	APC	Day Case & RDA	Spell	15,291	16,478	14,907,689	17,294,902	1,187	2,387,213	0	0	16,478	17,294,902	1,187	2,387,213
		Elective	Spell	1,303	1,157	6,043,996	6,364,617	-146	320,621	41	82,400	1,198	6,447,017	-104	403,021
	APC Total			16,593	17,635	20,951,685	23,659,520	1,042	2,707,835	41	82,400	17,676	23,741,920	1,083	2,790,235
	OPA	First	Attendance	40,840	37,354	9,266,928	8,610,042	-3,486	-656,886	2,853	996,833	40,207	9,606,874	-633	339,947
			Procedure	13,859	13,170	2,840,896	2,442,737	-689	-398,160	634	138,973	13,804	2,581,709	-54	-259,187
		Follow-up	Procedure	33,523	31,404	7,484,608	6,600,668	-2,119	-883,940	3,060	1,060,320	34,464	7,660,989	940	176,381
	OPA Total			88,222	81,928	19,592,432	17,653,446	-6,294	-1,938,986	6,547	2,196,126	88,475	19,849,572	253	257,140
Yes Total				104,815	99,563	40,544,117	41,312,966	-5,252	768,849	6,588	2,278,526	106,151	43,591,492	1,336	3,047,375
Grand Total				104,815	99,563	40,544,117	41,312,966	-5,252	768,849	6,588	2,278,526	106,151	43,591,492	1,336	3,047,375

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 M6 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 earnt. 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 acitity and income has been included.

Non Elective Best Practive Tariff (BPT) - this has not been applied in the processed income files. A BPT tariff value has been added to match to plan values for M6.

Elective Recovery Funding (ERF) – Forecast Risks: The YTD assessment of earnings supports the forecast expectation of £4.0m overperformance on ERF, caution is required to ensure that the Trust does not commit to premium cost activity delivery in excess of the ICB ERF overperformance envelope. It should also be noted that the estimated YTD position includes a £2.3m income adjustment where recording changes are required to bring the activity within SUS reporting as well as formal agreement to counting and coding changes notified to the ICB.

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) – M3 26/27 vs M3 25/26

M3	M3 26/27 vs M3 25/26
Inflation adj. expenditure growth	7.90%
Cost weighted activity growth	1.00%
Implied productivity growth	-6.40%

- 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.
- The first report for 2026-27 has been produced, however it should be noted that this will be affected by the following factors which significantly understate Trust activity:
  - SDEC activity is not included in national productivity data and will appear as a loss in non-elective activity
  - Not all Trust activity is being correctly reported to SUS, with some corrections required to adjust outpatient activity.
  - These metrics take full account of all Trust expenditure, but only acute activity, therefore all increases in ASC and CHC activity will appear as losses in productivity.

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.

NHS
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Finance Plan Delivery - Capital and Cash

Cash Position

NHS
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	(5.8)	(5.9)	(0.1)	7.4
Capital Non-Cash movements (depr&amort)	12.7	12.7	(0.0)	25.3
Working Capital Movement	(3.1)	(13.6)	(10.5)	(7.2)
Net cash generated from / (used in) operations	**3.8**	**(6.8)**	**(10.6)**	**25.6**
Net Capital Expenditure (Purchase/Disposals)	(28.0)	(19.3)	8.7	(44.5)
Interest Received	0.8	0.8	0.0	1.6
Net cash generated from/(used in) investing activities	**(27.2)**	**(18.5)**	**8.7**	**(42.9)**
PDC paid/received	6.4	(2.9)	(9.4)	(1.3)
Loans paid/received	(1.0)	(1.0)	(0.0)	(2.0)
Capital on finance leases and PFI	(2.1)	(2.0)	0.2	(5.1)
Interest element on loans, finance lease and PFI	(1.1)	(1.1)	(0.0)	(2.1)
Net cash generated from/(used in) financing activities	**2.2**	**(7.0)**	**(9.2)**	**(10.5)**
Closing cash balance	**18.3**	**3.2**	**(15.1)**	**7.7**

Cash Risk: Non-cash backed unknown balance sheet releases and failure to meet CIP targets remain as significant potential risks.

The closing cash balance for M6 is £15.1m 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 £10.6m below plan, primarily driven by the delay in receipt of the scheduled £6.2m from Torbay Council until after ledger close, along with some working capital timing differences.
- Investing activities show a £8.7m variance, mainly reflecting the movements in capital creditors accruals between M12 and M1, along with a £3.5m asset disposal at M6.
- The variance on financing activities relates to revenue PDC, which was planned to be drawn in M6 but was not applied for until M7 to be drawn in M08.

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(5.9)**
Finance income	0.8
Finance expense	(2.0)
PDC dividend expense	(3.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(10.2)**
Capital donations/grants/peppercorn lease I&E impact	(0.2)
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.2
TOTAL Provider Surplus/(Deficit) - System performance measure	**(10.2)**

Cash Forecast

NHS
Torbay and South Devon
NHS Foundation Trust

	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Start Date 01.10.2026	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Cash Balance B/F	9.4	4.6	11.0	1.2	10.3	11.4
Total Receipts	71.2	73.3	57.1	72.1	63.6	57.0
Total Payments	(76.0)	(66.9)	(66.9)	(63.0)	(62.5)	(60.7)
Net Movement	(4.8)	6.4	(9.8)	9.1	1.0	(3.7)
Cash Balance C/F	**4.6**	**11.0**	**1.2**	**10.3**	**11.4**	**7.7**

The Month 6 cashflow forecast has been prepared on the following basis:

- The cashflow forecast for M07–M12 2026/27 is based on the M07-M12 Trust performance forecast with a FY break-even position.
- The 2026/27 finance plan includes £10.193m of PDC Revenue Support drawn down in Q1-2 and repaid in Q4 (to match the profile of the planned revenue deficit). This forecast includes a drawdown of £10.193m of PDC Revenue Cash Support now in M08 and full repayment in M12.
- The capital outflows and associated funding sources are as per the Month 6 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 includes known balancesheet releases, but assumes no further unknown non-cash backed revenue changes are required to support the position.
- The H2 forecast includes significant working capital movements which were not included in the original plan. This additional cash pressure is expected to be managed through the remainder of the year due to the profile of capital receipts in excess of capital cash payments and will require resolution as capital accruals unwind in 2027-28, with options for resolution:
    - Improved working capital relating to transfer of ASC debt, and/or
    - Adjustment to planned capital programme financing to increase use of leases to fund equipment (such as linac) rather than outright purchase.

Cash Forecast

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The cashflow forecast is presented as Appendix 4 in the information pack, reflecting the £10,193k requested as PDC Revenue Support in November to be repaid in March, aligned to the Trust plan.

This forecast assumes full delivery of the Trust's revenue plan and no loss of DSF. Key assumptions and risks are noted below.

Forecast – Baseline cashflow forecast.

- This forecast reflects the agreed 2026/27 plan which includes DSF funding of £57.8m for the year (paid quarterly) and a break even position.
- The forecast **includes** drawdown of Revenue PDC Cash Support of £10.193m in M08 (to be repaid in M12). The trust has managed to maintain liquidity to date without this cash support however latest forecasts suggested that drawdown is now required as capital accruals from 2025-26 have fully unwound. The amount requested aligns with our agreed 2026/27 plan and YTD revenue position.
- The forecast assumes that the £6.2m monthly contractual income from Torbay Council is available at the beginning of the following month following the due date except in M12 when the council ledger closes early. Although the income is due on the final calendar day of each month, this has usually been received after the ledger has closed and the final payment run of the month has been committed.
- This forecast assumes 100% CIP will be achieved by M12.
- £7.6m cash balance to remain available on the 31st March 2027 to commit scheduled BACS payment run (funds leaving bank 2/4/2027).

- **Risks**
- CIP delivery remains a significant risk. Although forecast closing cash balances remain positive, margins are limited in some months, and under-delivery of CIP could result in a cash deficit. Potential mitigations include rephasing creditor payments and the capital plan, together with increased debt collection activity.
- An application for PDC Revenue Cash Support in M07 for drawdown in M08 has been submitted, but no approval has yet been received.
- Unplanned non-cash-backed balance sheet movements are a potential risk to the cash position.
- The treatment of ASC debtors when the function returns to Torbay Council has not yet been determined. Depending on the agreed treatment, this may provide an opportunity to mitigate any potential cash shortfalls. An analysis of the potential scenarios is under way as negotiations with the council continue.

Working Capital Update

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A detailed analysis of receivables and payables balances, ageing profile and trends is included at Appendix 5 of this report, summary information is provided below.

Receivables

- Excluding ASC receivables, total Trust receivables decreased by £3.3m compared with the Q1 2026/27 position. There was an increase in debt not yet due of £1.3m **so for all due debt, the result is a decrease of £4.6m** indicating effective debt control policies.
- Whilst total debt value has decreased, aged debts > 60 days has increased by £300k, however £166k of this, due from DPT has been agreed and is awaiting processing.
- One particular debt has been difficult to collect and litigation has commenced:
- **Automate Group** – The debt due from Automate totals £439k (incl. VAT) as of 30th Sep. This company was engaged to provide hot food machines at some locations in the Trust, and this debt relates to lease agreements the Trust holds for the equipment used which it rebills to Automate. A new contract has recently been agreed with Automate which includes an obligation for them to make an immediate payment of £100k to the Trust (due 18th June 2026 but not received).
- The agreement also requires Automate to settle the existing lease agreements held by the Trust for the equipment and to put its own leasing arrangements in place. No settlement has yet been reached with the leasing companies, so the Trust remains exposed to further debt while it continues to pay these lease costs and rebill Automate. The Trust's legal department is managing this matter; however, progress with Automate has been challenging.

Payables

- Trade payables have increased overall by £3.6m since Q1 2026/27. However, the increase in payables 'not yet due' is £7.2m which indicates an **effective decrease in all due payables of £3.6m.**
- BPPC performance for the year to date has again deteriorated from the previous quarter. More resource is currently focused on older balances ahead of the move to SBS, reducing the time available to chase approval of more recent invoices. Further communications are planned to all approvers and receipters to encourage timely approval; however, continued focus is required to maintain BPPC standards. To reduce future queries, work is under way with the SBS implementation to ensure all NHS invoices are PO-backed.

ASC Receivables

- ASC receivables continue to increase, albeit only an increase of £138k from Q1 to Q2, with an associated risk of bad debt write-off. The main drivers remain delays with probate and house sales, alongside an increase in full-cost clients.

Capital Programme and Funding Sources

Torbay and South Devon NHS Foundation Trust

Gross capital expenditure	YTD M6			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Property, land and buildings	1.9	7.3	5.4	9.1	20.9	11.8
Plant and equipment	1.1	2.0	0.9	3.3	5.0	1.7
IT	4.8	3.4	(1.4)	9.0	4.8	(4.2)
Other	1.5	0.0	(1.5)	2.6	0.5	(2.2)
Disposals / other deductions	0.0	(3.5)	(3.5)	0.0	(3.9)	(3.9)
Gross capital expenditure	9.3	9.1	(0.2)	24.0	27.3	3.3
Less PFI capital (IFRIC12)	0.0	0.0	0.0	(0.7)	(0.7)	(0.0)
Gross capital expenditure (excluding PFI/IFRIC12 impact)	9.3	9.1	(0.2)	23.3	26.6	3.3
Less grants, donations and peppercorn leases	(0.1)	(0.6)	(0.5)	(0.1)	(0.7)	(0.5)
Total CDEL (Including National PDC)	9.3	8.5	(0.7)	23.2	25.9	2.7
Total CDEL (Excluding National PDC)	9.3	7.5	(1.8)	22.3	22.8	0.5

Capital Cash Sources	YTD M6			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
National PDC Funding	0.0	1.1	1.1	0.9	3.2	2.2
Capital Support PDC	0.0	0.0	0.0	1.1	1.1	0.0
Depreciation	12.7	12.7	(0.0)	25.3	25.3	0.0
Lease funding	1.5	0.1	(1.4)	3.6	2.0	(1.6)
Lease capital repayments	(1.6)	(1.4)	0.2	(3.1)	(3.1)	0.0
PFI Capital repayments	(0.6)	(0.6)	(0.0)	(1.9)	(2.0)	(0.1)
Repayment of Borrowing	(1.0)	(1.0)	(0.0)	(2.0)	(2.0)	0.0
Donations	0.1	0.6	0.5	0.1	0.7	0.5
Other	(0.5)	(1.0)	(0.5)	(0.9)	(0.7)	0.2
Total Funding Sources	10.7	10.5	(0.2)	23.2	24.6	1.4

Capital CDEL Limits	YTD M6			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Trust CDEL Limit	9.3	7.5	(1.8)	22.3	22.8	0.0
Trust Funded CDEL	9.3	7.5	(1.8)	22.3	22.8	0.5
National PDC: Community Diagnostics Centres	0.0	0.0	0.0	0.8	0.3	(0.5)
National PDC: Endoscopy	0.0	0.0	0.0	0.2	0.2	0.0
National PDC: Tower Fire Safety	0.0	1.0	1.0	0.0	1.8	1.8
National PDC: Create standalone SDEC	0.0	0.0	0.0	0.0	0.9	0.9
National PDC Funded CDEL	0.0	1.1	1.1	0.9	3.2	2.2
Total CDEL	9.3	8.5	(0.7)	23.2	25.9	2.7

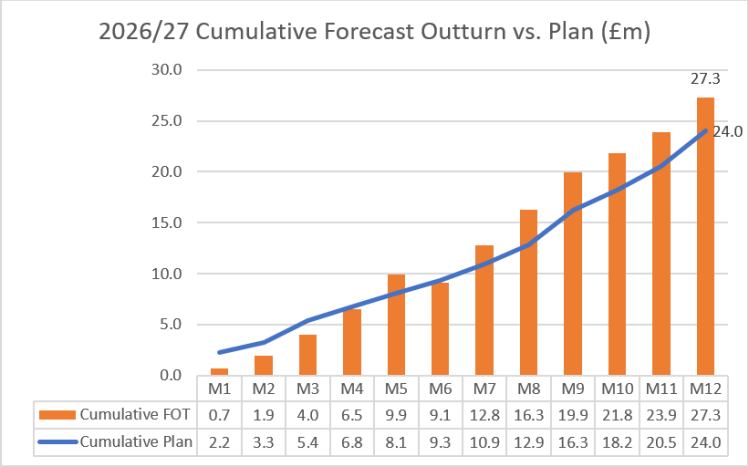
Capital Spend Month 6

- At Month 6, the Trust has spent £8.5m of capital compared to a plan of £9.3m, £0.8m behind plan due to an asset disposal in the month (-£3.5m).
- Total Operational CDEL increased to £22.8m from £22.3m reported at M5, reflecting CDEL reallocations between TSD, RDUH and UHP.
- An MoU for £946k for the creation of SDEC has been received, £54k less than previously reported, in line with the approved bid.
- Donated capital spend is £607k, including LoF and R&D funding, £544k above plan.

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**	**3.4**	**(0.7)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**9.1**
Property, land and buildings	0.1	0.4	1.5	0.8	2.5	2.0							**7.3**
Plant and equipment	0.0	0.0	0.0	1.7	0.1	0.1							**2.0**
IT	0.6	0.8	0.5	0.0	0.8	0.6							**3.4**
Other	(0.0)	0.0	0.0	0.0	0.0	(3.5)							**(3.5)**
FOT	**0.7**	**1.2**	**2.0**	**2.5**	**3.4**	**(0.7)**	**3.6**	**3.5**	**3.7**	**1.9**	**2.1**	**3.4**	**27.3**
Property, land and buildings	0.1	0.4	1.5	0.8	2.5	2.0	2.6	2.7	1.9	1.6	1.7	3.0	**20.9**
Plant and equipment	0.0	0.0	0.0	1.7	0.1	0.1	0.1	0.5	1.3	0.2	0.3	0.7	**5.0**
IT	0.6	0.8	0.5	0.0	0.8	0.6	0.7	0.2	0.3	0.0	0.0	0.0	**4.8**
Other	(0.0)	0.0	0.0	0.0	0.0	(3.5)	0.1	0.0	0.1	0.1	0.1	(0.3)	**(3.4)**



Capital Forecast

- The Trust's capital programme included a cash requirement of £1.1m at the start of the year, for which an MoU has been received. Due to changes in our CDEL, a further cash requirement has arisen and another application for £1.3m will be submitted.
- The Trust is forecasting to spend up to capital limits and continues to bid for additional national funding opportunities as they become available.
- MoU has been received of £946k PDC funding for the creation of SDEC.
- £1.5m of R&D funding for the Aseptic Suite scheme has been confirmed, with spend planned for 27/28.

Statement of Financial Position

Torbay and South Devon NHS Foundation Trust

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	318.4	300.6	(17.8)
Other Non-Current Assets (Receivables)	4.0	4.2	0.2
Cash & Cash Equivalents	18.3	3.2	(15.1)
Working Capital (excl cash)	(43.5)	(35.4)	8.1
Non-Current Liabilities (Loans/Leases/Other)	(50.7)	(50.6)	0.2
Total Assets Employed (Assets + Liabilities)	**246.5**	**222.0**	**(24.5)**
Public Dividend Capital	366.2	359.5	(6.7)
Revaluation	60.7	55.0	(5.7)
Surplus / (Deficit) Sub Total	(10.7)	(10.2)	0.5
I&E reserves	(169.8)	(182.4)	(12.6)
Reserves Total	**246.5**	**222.0**	**(24.5)**

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(5.9)**
Finance income	0.8
Finance expense	(2.0)
PDC dividend expense	(3.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(10.2)**
Capital donations/grants/peppercorn lease I&E impact	(0.2)
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.2
TOTAL Provider Surplus/(Deficit) - System performance measure	**(10.2)**

- Fixed assets are **£17.8m** below the plan. This is driven by the 2025/26 asset revaluation of **£15.5m.** The remaining variance reflects capital disposals YTD of £3.5m and movements in capital accruals.
- Cash is **£15.1m** below plan, explained in detail in cashflow report.
- 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 **£6.7m** reflects the net impact of £3.5m additional system capital funding for EPR, allocated late in M12 and therefore not included in the planning return, together with £10.2m less than plan of planned Revenue PDC support that had not yet been requested or drawn down.
- I&E reserves variance of **£12.6m** reflects the DV PPE revaluation in 2025/26.

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Regional Performance Monitoring

Red Flag Dashboard

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South West Red Flag Dashboard - Breakdown by Theme - Month 5 2026-27

Please select >>>	T&SD	Provider Trend	Month 5 2026-27 Raw	Month 5 2026-27 Rounded	Month 4 2026-27 Raw	Month 4 2026-27 Rounded	Movement
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		2.0	2.0	2.0	2.0	0.0
	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	4.0	4.0	0.0
	Efficiency Variance FOT		1.0	1.0	1.0	1.0	0.0
	High Risk Efficiency		1.0	1.0	1.0	1.0	0.0
Cash	Cash metric		4.0	4.0	4.0	4.0	0.0
	Opex Days (RAM)		4.0	4.0	4.0	4.0	0.0
	Revenue Cash Support		1.0	1.0	1.0	1.0	0.0
	Capital Cash Support		2.0	2.0	3.0	3.0	(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	3.0	3.0	0.0
	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	3.0	3.0	0.0
	Implied Productivity Direction of Travel		3.0	3.0	3.0	3.0	0.0
ULP	Underlying Position		4.0	4.0	4.0	4.0	0.0
Other	NOF Rating		3.0	3.0	4.0	4.0	(1.0)
	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**	**2.6**	**3.0**	**(0.0)**
	Raw Score with Override		**2.5**	**3.0**	**2.6**	**3.0**	**(0.0)**

Please note this is the automated assessment prior to any regional manual override

NHS England has created a 'Red Flag Dashboard' to monitor financial performance.

The Trust performance remains broadly consistent month on month.

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Actions

Actions

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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
Work with Performance and Ops teams to forecast impact of data corrections, productivity improvements and proposed additional capacity on contract delivery.	Ongoing
Assess all available options to close the forecast risk gap and deliver financial plan, including 'unpalatable' and high risk options.	November 2026

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TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

QUARTERLY PERINATAL TRUST BOARD SAFETY REPORT

Reporting period	October 2026
Quarter	Quarter 2: July – September 2026
Date of Board/Committee	October 27th 2026
Report authors	Perinatal Leadership team
Executive lead	Nicola Mcminn/Kate Lissett
Presented by	Joanna Bassett

Purpose: To provide the Trust Board with a quarterly, integrated view of maternity and neonatal safety, quality, learning, workforce, equity, risks and assurance.

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1. Trust performance against national safety ambitions

Metric	Latest month	Quarter position	SPC interpretation	Action / assurance
Number of births	168	467	Marginal increase in births	Continue oversight
Stillbirth rate per 1,000	0	2.1	No Increase	Continue PSR/PMRT and monitoring
Neonatal death rate per 1,000	0	0	Stable	Continue real-time mortality monitoring
HIE rate per 1,000	0	2.1	July event under review	Continue incident learning
Unexpected admissions to NNU	4.6%	4.33%	Slight reduction in available data	Continue ATAIN oversight
Date of last stillbirth	31 August 2026	Term stillbirth within Q2	Under review	PSR, PMRT and family engagement
Date of last neonatal death	7th January 2026	No Neonatal death within Q2	Stable	Continue to monitor
Average days between neonatal deaths	n/a	n/a	21 days on average over the last year for babies who were born in Torbay who died either here or elsewhere. However there have been no deaths since Jan.	Continue to review
Date of last HIE	July 2026	Suspected HIE transfer within Q2	Case under review	Continue to review
Average days between HIE	n/a	91 Days since HIE in Q2.	51 days on average for babies requiring cooling in the last 12 months.	Continue to review

DATES	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Trend	Interpretation
Number of births	145	136	140	148	144	148	123	138	158	158	161	138	168		Assure
Stillbirth rate (per 1000)	0	0	0	0	6.94	0	0	0	0	6.32	0	7.25	0		Assure
Neonatal death rate (per 1000)	0	0	7.14	0	0	0	0	0	0	0	0	0	0		Assure
HIE rate (per 1000)	0	0	0	0	0	0	0	0	6.32	0	6.21	0	0		Assure
Unexpected admissions to NNU (%)	7.4%	4.0%	7.1%	5.1%	10.9%	4.4%	8.8%	8.5%	3.5%	2.1%	3.50%	7.40%	4.60%		Assure
3&4 degree tears	4.2%	7.7%	6.8%	2.5%	3.1%	5.6%	3.0%	4.3%	2.8%	2.6%	7.10%	2.80%			Await data
PPH >1500	4.1%	4.4%	3.6%	0.7%	4.3%	1.4%	1.6%	2.2%	1.9%	4.5%	6.30%	4.50%	3.00%		Assure
1-1 care in labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%		Advise
Smoking at time of delivery	2.8%	2.2%	3.6%	5.4%	2.1%	2.0%	2.4%	2.2%	0.6%	3.9%	3.10%	3.70%	4.20%		Advise

One-to-one care has now been added to Epic. The drop in compliance relates to the change in data collection rather than a drop in performance. This metric is no longer mandated as reportable too.

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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 of 4.2% is checked for accuracy by smoking cessation team. Quarterly total of 3.66%

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2. Reported incidents and thematic learning

Incident / review type	Summary	Action implemented	Family view / Duty of Candour	External reviewer / status
Open moderate-or-above reviews	Multiple open PSRs/PSII/MNSI and case reviews continued across the quarter, creating delay pressure.	Weekly review of cases established.	Duty of Candour completed or in progress; comments invited where applicable.	Mixed: draft, action-plan development or external review
MNSI case MI-061844	Severe neonatal jaundice / suspected kernicterus case remained under MNSI review.	PSR was completed and the interview process was initiated.	Family follow-up through the investigation process.	MNSI accepted
Term stillbirth, 31 August 2026	Stillbirth following reduced fetal movements.	PSR and Duty of Candour documentation commenced.	Duty of Candour in draft at reporting point.	Internal review in progress
Closed events	No moderate or above events were reported closed in July or August.	Weekly monitoring continues.	Not supplied / not applicable	Open backlog remains

Thematic learning from investigations

Theme	Prioritised learning and actions	Outcome / improvement	Impact of earlier actions	Executive Board support required
Clinical deterioration	Strengthen recognition, escalation and emergency response; review ROTEM access and competence.	Examples of prompt escalation and MDT response were identified.	Further impact audit required.	Support closure and impact measurement.
Communication and personalised care	Improve shared decision-making, safety-netting, and family information.	Positive feedback on kindness and explanations; concerns remain.	Mixed evidence.	Maintain oversight.
Documentation and record quality	Improve emergency, PPH and screening documentation; reinforce EPIC workflows.	Action under way; BI/dashboard work ongoing.	Data quality still limits assurance.	Support BI/EPIC capacity.
High-risk and neonatal pathways	Strengthen pathway compliance, neonatal assessment, failsafe and escalation.	Screening and incident actions are initiated.	Outcome evidence is pending.	Support cross-organisational ownership.

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Triangulated themes

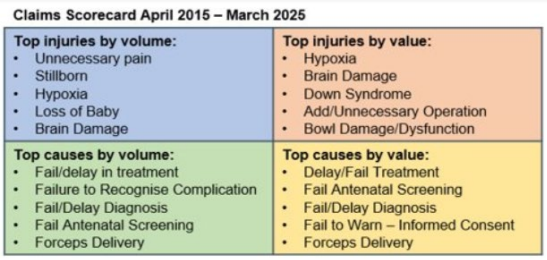
Source	Key theme	Triangulation with other intelligence	Risk / action
Incidents/reviews	Deterioration, escalation, documentation and high-risk pathway compliance	Aligns with PPH audit, MEOWS/NEWTT2 findings and training gaps	Weekly review, targeted training and action tracking
Service-user feedback	Communication, appointment management, estates/privacy and partner presence	Aligns with staffing pressure, EPIC optimisation and estates risk	MNVP co-production, overnight partner launch and estates options appraisal
Workforce data	Acuity pressure, fill-rate variation and neonatal skill-mix constraints	Aligns with red flags, John MacPherson acuity and service-user access concerns	Workforce review and redeployment controls
Training	Medical and mandatory training below required thresholds	Aligns with MIS Year 8 risk and emergency response learning	Additional dates, individual follow-up and compliance monitoring
Guideline tracker	Delayed response, Obstetric input and allocation	Aligns with governance backlog and need for timely implementation	Escalation, ratification meeting and monthly tracking

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3. Coroners reports and Regulation 28

Date listed	Case / report summary	Current status	Risk / learning
Q2 2026/27	No Coroner Regulation 28 reports identified.	Nil reported	Continue monitoring

4.NHS Resolution scorecard and claims learning

Themes from Claims Scorecard (10 years)	Themes from complaints (current)
	Communication; cancelled appointments; medication and antenatal care; triage/ward care; retained placenta.

Themes from maternity and neonatal patient safety incidents	Themes from staff, family, FSU or other sources
Deterioration/escalation; fetal monitoring; PPH; documentation; neonatal assessment; high-risk pathways.	Staff frustration with estates and EPIC; compassionate care and clear communication reported by families.

Improvement action from identified themes	Measure of impact	Outstanding risk	Mitigation / owner
Weekly case review and thematic review	Progress and closure of PSRs/actions	Backlog and delayed evidence of impact	Governance team / weekly and monthly review
Targeted training and simulation	Compliance and drill completion	Training remains below threshold in several groups	Education Lead
Improve documentation and data capture	Audit and dashboard completeness	EPIC data quality limits assurance	Digital/BI and clinical leads

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5. Perinatal Improvement Plan

Priority / programme	RAG	Progress this quarter	Evidence of impact	Next milestone	Owner
Workforce and acuity		Monthly monitoring; staffing model and DAU/triage capacity review in progress.	1:1 labour care maintained; variable acuity/fill rates.	Complete workforce trajectory and staffing review.	Perinatal leadership team
Training / MIS		Additional dates and individual follow-up; fetal monitoring reached 90%; anaesthetic PROMPT 86%.	Recovery trajectory described but several mandatory modules remain below target.	MIS submissions and >90% recovery evidence.	Education Lead
Guideline recovery		29/60 in review or in the approval pipeline. Extraordinary ratification meeting planned.	Structured tracker and escalation established.	Progress 15 through sign-off/upload; resolve 29 requiring follow-up/allocation.	Clinical Effectiveness / Team
MOSS and mortality oversight		Pre-alert complete; monthly checks undertaken; full drill scheduled.	Routine monitoring is in place.	Complete and evidence drill actions.	MD
Maternal Care Bundle		Four of five leads engaged; four areas benchmarked; plan prepared for Board approval.	PPH thematic review provides a baseline for element implementation.	Approve plan and complete self-assessment/implementation.	MCB leads
Screening/failsafe resilience		Incident reviews, blood-order-set reinforcement, recruitment and NIPE training under way.	Strong uptake overall; pathway risks remain.	Close QA actions and strengthen shared care failsafe.	Screening team

Escalations and support

Escalation	Support required	Progress since previous escalation	Board action
Workforce capacity and acuity	Support staffing models, recruitment and dedicated triage/DAU capacity actions.	Q2 worsened, with red flags 5→19→66 and acuity falling to 60% LW and 36% JM.	Maintain executive oversight and remove barriers.

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Escalation	Support required	Progress since previous escalation	Board action
PPH improvement	Support implementation of Cumulative Maternal Blood loss, standard escalation, and documentation recommendations.	Thematic review completed; September >1500 ml was 4.77%.	Receive evidence of implementation and impact.
Training, digital and screening resilience	Protect training attendance and provide BI/digital and screening capacity.	Recovery dates and mitigations are active; material gaps remain.	Monitor MIS trajectory and risk controls.

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6. Performance metrics

6.1 Service suspensions

Service	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Obstetric unit	0	0	0	0	0	0						
Midwifery-led unit	0	1	0	6	3	14						
Homebirth service	0	2	1	7	3	14						
Neonatal unit (internal)				0	0	0						
Neonatal unit (external)				0	1	2						

Reason / theme	Mitigation	Impact	Ongoing risk / escalation
Midwifery led births were suspended due to inability to release midwives from the acute site due to staffing / acuity pressures,	Offer midwifery led births in the unit/ birthing pool available	Will impact on some women's choice – communication around rationale supplied. No complaints received from service users	Will review suspension reversal on each occasion that acuity is reviewed during the day.
SCBU recorded no internal suspensions during Q2. External neonatal cot capacity was restricted on three occasions (one in August and two in September), affecting the unit's ability to accept transfers from other organisations.	Capacity and staffing were reviewed in real time, with admissions clinically prioritised and regional neonatal network escalation used to identify alternative cot capacity where required.	There was no restriction on internal neonatal care. External restrictions may have delayed or redirected transfers into Torbay; no associated adverse outcome is identified in the reported data.	Continuing daily capacity and staffing oversight, with timely neonatal network escalation. Review each restriction to identify recurrent capacity or workforce factors and monitor the Q3 position.

6.2 Delays to induction of labour over 6 hours

Measure	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of delays >6 hours for admission	1	8	12	9	8	19						
Number delayed > 6 hours for decision for ARM to transfer to LW for 1:1 Care				6	5	9						
Number of women who have prolonged SROM >24 hours and planned IOL is delayed				0	0	4						

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Reason / theme	Mitigation	Impact	Ongoing risk / escalation
Delays to induction of labour continue to occur at times of increased service demand and reduced capacity, with some women experiencing a delay beyond their planned induction date/time.	Daily oversight and prioritisation of planned inductions is in place, with clinical risk informing sequencing. Women experiencing delays are reviewed, kept informed and provided with an updated plan of care.	Delays can adversely affect women's experience and increase anxiety, as well as creating potential clinical risk where induction has been recommended for a specific maternal or fetal indication.	IOL activity and delays are monitored through maternity operational and governance processes, with escalation where capacity affects timely care. Themes and contributory factors are reviewed to support ongoing improvement.

7.3 Delays to elective caesarean section over 24 hours

Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number delayed >24 hours	2	6	6	2	5	Data awaited						

Reason / theme	Mitigation	Impact	Ongoing risk / escalation
Planned elective caesarean sections can be delayed or postponed when service pressures, particularly emergency activity, affect available theatre or staffing capacity.	Cases are clinically prioritised according to indication and gestation, with senior oversight of capacity and escalation where planned activity is affected. Women experiencing delays are kept informed and provided with a revised plan.	Delays can adversely affect women's experience, increase anxiety, and, where delays are prolonged, create potential clinical risk depending on the indication for birth.	Delays and postponements are monitored through maternity operational and governance processes, with themes and capacity pressures reviewed to identify opportunities for improvement and reduce avoidable delays.

7. Home births and births before arrival

No. home births / BBA	No. birthing at home against medical advice	No. with MDT plan	No. transferred to acute unit	No. transfers with delay
Quarter total not supplied; one September BBA with 1.5 l PPH reported	Not supplied	Not supplied	One transfer-in event reported	Not supplied

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Learning and action from incident review and audit

Learning	Action	Progress / impact	Owner
Governance for planned homebirth outside guidance required	Introduce tracker for personalised plans, MDT oversight, transfers and learning.	Tracker proposed for integration into PQOM.	Outpatient Matron

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8. Maternity triage

Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of triage presentations	562	601	634	662	619	658						
% Red	0.4	0.7	0.3	0.3	0	0						
% Orange	6.4	4.3	3.8	3.2	5.2	3.6						
% Yellow	20.3	18.8	20.2	19.2	26.8	29.8						
% Green	7.3	7.2	6.2	3.9	2.7	4.6						
% Unable to determine (incorrect documentation to provide information)	65.7	69.1	69.6	73.4	65.1	61.9						
% assessed within 15 mins of arrival	39.1	35.1	36.8	36.9	40.9	40.1						
Number of breaches	3	0	2	2	0	0						
% leaving without further review	-	-	-	-	-	-						

Key finding	Cause / theme	Action and mitigation	Impact / trajectory	Escalation
Triage demand and attendance is increasing with improvement needed in % being assessed within 15 minutes	Midwifery staffing levels to complete the initial assessment remain under the recommended staffing level based on national specification for triage	Continue review of triage/DAU capacity and staffing as part of the maternity workforce review. This gap was highlighted within the 10-point plan audit assessment	Performance against the 15-minute assessment measure remains broadly static at around 40%.	Maintain senior oversight of triage capacity and workforce. Board level oversight via this dashboard
Documentation/data quality significantly limits assurance.	Incomplete/incorrect documentation prevents reliable assessment of acuity and performance.	Strengthen documentation and data-quality processes alongside ongoing EPIC/BI work.	Some improvement across Q2, with “unable to determine” reducing from **73.4% to 61.9%**, but this remains high.	Continue governance oversight until data quality provides greater assurance.

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9. Training compliance and simulation

Training requirement	Midwives	Obstetric consultants	Other obstetric doctors	MSWs	Anaesthetists	Neonatal consultants	Other neonatal doctors	Neonatal nurses / ANNP
Obstetric emergency training (PROMPT)	92	90	71	97	86			
Fetal monitoring and surveillance	91	89	71					
Neonatal resuscitation training	92					95	95	91

In-situ multidisciplinary simulation

Setting	Date and location	MDT teams involved	Themes / learning	Actions taken / impact
Out-of-hospital birth	August 2026	Multidisciplinary maternity team	Emergency response in out-of-hospital setting	Simulation completed
Impacted fetal head	Planned for October 2026	MDT	MIS-aligned emergency drill	Planning in progress

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10. Staffing and workforce

Staff group	Establishment WTE	In-post WTE	Vacancy WTE	Vacancy rate %	Trend
Midwifery	August 107.96wte Sept 107.96wte	August 102.63wte Sept 101.34wte	August 5.32wte September 6.61wte	August 4.92% September 6.12%	Deteriorating
Maternity support workers	August 29.47wte Sept 29.47wte	August 28.74wte Sept 27.85wte	August 0.73wte September 1.62wte	August 2.47% September 5.49%	Sickness and fill-rate pressure varied; MSW night fill fell to 36.6% in September
Obstetric consultants (September data)	13 WTE	11.38 WTE	1.62	12.46%	No consultant locums used in Q2; internal cover maintained. Active recruitment in progress.
Obstetric resident doctors	19.5	19.02	0.48	2.46%	
Neonatal nurses					See table below
Neonatology consultants					See table below.
Neonatology resident doctors					See table below.
Obstetric anaesthetists					Rota compliance 100% July and August; September not supplied

Neonatal Workforce Dashboard (Quarterly)
2026/27

Indicator	Target	Q1	Q2	Q3	Q4	RAG
Nursing shifts meeting BAPM staffing requirement	≥90%	93%	96%			Green
Medical shifts meeting BAPM staffing requirement	100%	100%				Green
QIS coverage of required shifts	100%	100%	100%			Green
QIS nurses in post (% of total trained workforce)	min 70% *	50%	58%			Amber
QIS nurses in training		2	2			

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Staffing escalations	0	0	0	Green
Staffing-related service restrictions	0	0	0	Green
Capacity-related service restrictions	0	0	1	Amber

RAG Criteria

Measure	Green	Amber	Red
BAPM nursing compliance	≥90%	80-89%	<80%
Medical staffing compliance	100%	95-99%	<95%
QIS trained %	≥70%	55-70%	<55%
Staffing escalations	0	1-2	>2
Service restrictions (staffing/capacity)	0	1	≥2

Workforce risks and mitigations

Risk	Mitigation	Impact / control effectiveness	Escalation / support required	Owner
Maternity acuity and day-fill pressure	Daily review, redeployment, and staffing model review	1:1 care maintained, but July/August acuity remained below target	Executive support for establishment and triage/DAU capacity	PLT
Neonatal QIS capacity and skill mix	Aim to cover shifts with three registered nurses: workforce review	BAPM fill improved, but QIS remained beneath BAPM compliance level	Workforce plan and trajectory required	Neonatal leadership team
Training compliance	Extra dates, prioritised attendance, and individual follow-up	Some improvement, but multiple modules remain below target	Maintain MIS oversight	Education Lead
Data quality/EPIC	BI support and encounter mapping	Work begun; full assurance not available	Dedicated BI/digital capacity	Digital/BI leads

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11. Safety Champions feedback

Feedback raised by staff	Action and progress	Impact / outcome
Acuity, staffing and skill mix	Continuing monitoring and redeployment; maintain competence across settings	Controls active; outcome trajectory remains variable
Estates restrictions	Continue options appraisal	Risk remains open
EPIC challenges	Bespoke superuser/floor support and dashboard work being progressed	Improvement work under way

Feedback raised by service users	Action and progress	Impact / outcome
Compassionate, kind and supportive care	Continue reinforcing and sharing positive feedback	Eight service-user compliments reported for August
Communication, appointments and ward/triage concerns	Complaint review, EPIC optimisation and service-level actions	Impact to be monitored
Partners staying overnight and neonatal parent facilities/privacy	Overnight partner launch planned; estates options appraisal	Implementation/impact monitoring required

Additional Safety Champions intelligence	Action and progress	Impact / outcome
MNVP card collection interrupted by letterbox/data-confidentiality issue	New collection process being developed with MNVP	Feedback capture gap remains

Escalations and support

Escalation	Support required	Progress from previous escalation
Nothing to escalate		

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12. Perinatal Cultural Improvement Plan

Theme	Baseline / objective	Progress this quarter	Evidence of impact	Support requirements	RAG
Listening to Women and Families	Improve family experience through overnight partner arrangements, enhanced SCBU facilities and an integrated Birth After Thoughts service.	Overnight partner processes and guidance completed for 5 October launch. SCBU estates paper submitted. Additional Birth After Thoughts midwife advertised and planning meeting arranged.	Implementation readiness demonstrated; service-user impact measures will follow launch. Estates and integrated service outcomes are not yet evidenced.	Director of Estates feedback and continued multidisciplinary support to embed and evaluate the three priorities.	
Workforce	Develop a sustainable perinatal workforce strategy, complete the maternity service review, and achieve required medical mandatory training compliance.	Community caseload and activity data presented to senior leaders; service-redesign options discussed. Workforce strategy engagement and mandatory-training recovery actions continue.	Service-review work is on track, but the workforce strategy and mandatory medical training remain off track, with impact not yet demonstrated.	Protected multidisciplinary input to complete the strategy, progress redesign options and secure compliance with MIS training requirements.	
Culture and Leadership	Strengthen psychological safety, leadership visibility, handover, and escalation across the perinatal service.	Psychological safety strategy developed with broad stakeholder involvement but paused for Trust alignment. To be launched by the end of October. Maternity OPEL is operational; evidence collation and neonatal alignment continue. Handover toolkit launch delayed by operational pressures.	Key products and processes exist, but consistent implementation, neonatal priorities, and measurable impact are not yet established.	Trust-wide strategy alignment, access to SitRep evidence and protected capacity to recover handover and escalation milestones.	

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Theme	Baseline / objective	Progress this quarter	Evidence of impact	Support requirements	RAG
Clinical Pathways and Infrastructure	Implement national best practice for maternity triage, the Maternal Care Bundle, Martha's Rule, neonatal pulse oximetry and BFI accreditation.	Triage 10-point benchmarking and baseline audit completed; workforce costing and improvement plan progressing. Maternal Care Bundle benchmarking and guidelines are underway. Neonatal pulse oximetry guidance is nearing approval, and most BFI audits are complete.	Governance routes and baseline assessments are established; one of five Maternal Care Bundle areas is green and four amber. Full implementation impact is pending.	A formal resourced triage staffing plan, completion of benchmarking and guidelines, and agreement of maternity and network Martha's Rule pathways.	
Governance	Embed the governance framework, implement one auditable action-tracking system and recover overdue clinical guidance.	Governance Framework ratified and published; new Perinatal Governance and Safety Champions Committees established. Reporting schedules and PQOM assurance approaches introduced. Draft action tracker developed and guideline backlog prioritised.	Clearer floor-to-Board routes and structured oversight are in place. Consistent tracker use, closure evidence and sustained guideline recovery remain to be demonstrated.	Dedicated BI capacity, protected governance time, central SharePoint repository and administrative support; escalation where ownership or completion remains unresolved.	

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13. Service user insight, equity and MNVP co-production

Source / group	Insight or theme	Co-produced action	Progress / impact	Equity consideration
Maternity experience feedback	Compassionate care; communication and access concerns	MNVP engagement and overnight partner work	Implementation in progress	Assess by deprivation, ethnicity, interpreting need and geography
Equity dashboard	Strong early access overall; population becoming more diverse	Further stratified analysis proposed	Data completeness improving	Avoid reliance on aggregate figures
MEWS audit	Lower repeat-observation compliance in deprivation score <=3 group	Include equity in improvement action	Baseline identified	Targeted improvement required
NEWTT2 audit	Low repeat-observation compliance in deprivation and non-White British groups	Include equity in deterioration response improvement	Baseline identified	Targeted improvement required
Neonatal experience	Parent facilities/privacy and repatriation transition	Checklist/support groups/environment work proposed	In progress	Consider access and transport barriers

Quarterly narrative
What women and families told us: staff were frequently described as kind, compassionate, supportive and communicative. Areas for improvement included communication, cancelled appointments, privacy/parent facilities, overnight partner arrangements and access to help in busy periods.
What we changed: overnight partner arrangements were progressed; MNVP feedback collection was reviewed; EPIC optimisation and estates options appraisal continued.
How we know it made a difference: August recorded eight service-user compliments, but formal MNVP card collection was disrupted, and outcome evaluation remains incomplete.
What remains to be addressed: estates constraints, consistent communication, reliable feedback capture, equitable experience and evidence of impact.

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14. Saving Babies Lives Care Bundle v3.2

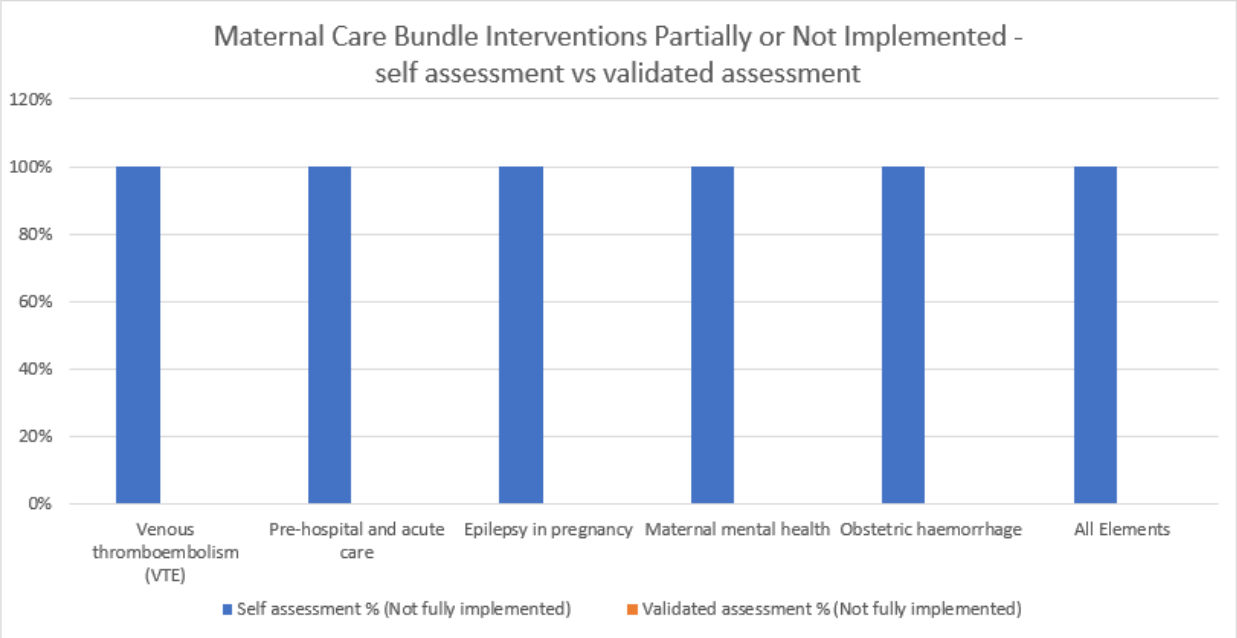
Element	Compliance / progress / action	Evidence / measure	Responsible role	By when	RAG
1. Smoking in pregnancy	70 %	August smoking at birth is 3.6%; regional concern relates to CO-recording evidence.	Public Health & Digital Midwife		Alert
2. Fetal growth	95 %	Quarter 1 audit.	Transformation Midwife		Assure
3. Reduced fetal movement	100 %	Incident review and pathway audit.	Clinical governance		Assure
4. Fetal monitoring	80 %	Training and incident review.	Fetal monitoring lead		Advise
5. Preterm birth	84.62 %	Audit and equity dashboard narrative.	Transformation Midwife		Advise
6. Diabetes in pregnancy	100 %	Not supplied / not applicable	Transformation Midwife		Assure

Summary
What is going well: Trust-level accountability and quarterly audit arrangements are established; fetal growth audit findings were positive, and fetal monitoring training reached 90%.
What is of concern: CO monitoring evidence in EPIC remains non-compliant; reduced fetal movements remains a learning theme and detailed element-level Q2 compliance is not fully available.
Top contributors: EPIC data quality, pathway audit findings, training recovery, and implementation of incident-learning actions.

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15. Maternal Care Bundle implementation

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Not implemented	0%		0%	No
Element 2	Pre-hospital and acute care	Not implemented	0%		0%	No
Element 3	Epilepsy in pregnancy	Not implemented	0%		0%	No
Element 4	Maternal mental health	Not implemented	0%		0%	No
Element 5	Obstetric haemorrhage	Not implemented	0%		0%	No
All Elements	TOTAL	Not implemented	0%		0%	*If yes, please refer



Exception narrative
Implementation grading: All five leads engaged and all areas benchmarked; implementation plan and the governance and reporting framework have been prepared for Board approval.
Areas below trajectory: full implementation and outcome measures not yet evidenced; PPH documentation and escalation gaps identified.
Corrective actions: add VTE questions to referral form, update SOPs and pathways, standardise escalation from 500ml blood loss, and standardise documentation.
Evidence of impact: baseline thematic review complete for PPH; post-implementation outcome evidence pending.

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The Maternal Care Bundle (MCB) implementation programme has now entered phase 2 and continues to progress in line with the implementation plan. Governance arrangements have been strengthened through the establishment of a dedicated governance and reporting framework, providing enhanced oversight of implementation progress, risk management, evidence validation and assurance reporting. Focus during the previous phase has been on completing the benchmarking of all elements and progressing delivery across the five MCB elements, embedding programme governance, validating baseline evidence and advancing priority actions identified through the initial self-assessment.

Monthly monitoring arrangements are now established, supported by action tracking, risk oversight, and performance reporting to ensure progress remains aligned to the agreed trajectory towards full implementation. Whilst several interventions remain in development, the programme continues to build capability through pathway review, workforce engagement, and multidisciplinary collaboration.

Key risks and dependencies are being actively monitored through the governance structure, with recovery actions in place where required. As the programme moves through phase 2, emphasis will focus on accelerating delivery of outstanding actions, strengthening evidence of implementation and demonstrating measurable improvement against the agreed compliance milestones and March 2027 implementation target.

The Committee is asked to acknowledge and approve the Implementation Plan and the Governance and Reporting Framework (see appendices) as part of the ongoing MCB development and as a requirement for the Year 8 Maternity Incentive Scheme (MIS).

**Please note there is a fault with the top table image where it does not show 'partially implemented' unless one section within an element is 'fully implemented.' This has been fed back to the regional team. Assurance is given to the Board that all areas are 'partially implemented' at this time. Due to the settings on the spreadsheet, we are unable to fix this issue internally.*

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16. Maternity Incentive Scheme Year 8

Safety action	Assessment (met / partially met / not met)	Evidence of compliance	Gaps requiring action	Owner	RAG
A. Workforce and capacity	Partially met	Maternity workforce monitoring and rota controls in place.	Neonatal workforce information, start feedback, and engagement meetings.	Head of Midwifery	
B. Training	Partially met	Additional training dates; fetal monitoring 90%; anaesthetic PROMPT 86%.	Training for certain roles remains below ≥90% standard.	Education Lead Midwife	
C. Learning from reviews and investigations	Partially met	Weekly review, thematic reporting and PSR/MNSI processes active.	On track	Governance Co-Ordinators	
D. Service user voice and equity	Partially met	Complaints, compliments, MNVP, and equity dashboard reviewed.	MNVP capacity	Transformation Midwife	
E. Care bundles	Partially met	SBL audit and the MCB implementation plan are ready for approval.	Smoking and CO data as part of saving babies' lives care bundle	Perinatal Compliance Lead	
F. Board oversight, governance, culture and leadership	Partially met	PQOM, Safety Champions and governance reporting structures active.	On track	Perinatal Compliance Lead	

Summary
What is going well: Governance oversight, workforce monitoring, review processes, and care-bundle implementation plan is ready for Board approval.
What is of concern: Training, workforce acuity, neonatal QIS capacity, data quality, open reviews and care-bundle implementation plan requires sign off before 30th November deadline.
Top contributors: Additional training dates, weekly case review, action tracking and programme leadership support progress; workforce pressure and digital constraints limit delivery.
Committee action required: Note partial compliance, maintain executive oversight and support workforce, training, BI/digital and screening resilience actions. Review and approve the MCB Implementation Plan and MCB Governance and Reporting Framework.

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17. Risks, mitigations and Board assurance

Risk / issue	Risk register reference	Current rating	Controls and mitigations	Gaps in control	Trajectory	Executive owner	Board action
Maternity workforce capacity and acuity	Not supplied	Red	Daily review, redeployment, staffing-model and DAU/triage review.	Red flags and acuity/fill-rate performance deteriorated markedly in September.	Deteriorating	Perinatal Leadership Team	Support workforce and recruitment actions.
Neonatal QIS capacity	Not supplied	Red/ Amber	Aim for three registered nurses and workforce review.	49.9% QIS in July/August against >70% target; September not supplied.	Static in available data	Neonatal leadership	Support recovery trajectory.
Training compliance / MIS	Not supplied	Amber	Additional dates, individual follow-up and protected attendance.	Multiple groups and modules remained below standard.	Recovery active	Education leadership	Maintain oversight.
Risk 381: delayed hyperbilirubinaemia identification	381	Red	Business case for bilirubinometers; suspected jaundice assessed on antenatal ward.	Insufficient community bilirubinometers.	Active mitigation	Maternity leadership	Support equipment solution.
Screening Fail Safe inaccuracies	617	Rating not supplied	Incident review, blood-order-set reinforcement and failsafe checks.	Cross-organisational pathway and reporting vulnerability.	New in September	Screening leadership	Maintain oversight.
Single point of failure in Digital Midwife role	618	Rating not supplied	Operational support and resilience planning.	Single-person dependency.	New in September	Digital/maternity leadership	Support resilience plan.
Neonatal BadgerNet data quality	615	Rating not supplied	Data-quality review and governance oversight.	Potential impact on national reporting, funding accuracy and assurance.	New in September	Neonatal leadership	Monitor corrective action.
Guideline backlog	Not supplied	Amber	Monthly tracker, escalation and extraordinary ratification meeting.	29 items required response/input/allocation on 6 October.	Mixed	Clinical Effectiveness	Support owner accountability.

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Appendix 1. Data measures for the Perinatal Quality Oversight Tool

Metric	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Quarterly note
Findings of reviews of all perinatal deaths using real-time monitoring				MOSS and MBRRACE checks completed; no PMRT completed	MOSS check 20/08/26; no PMRT completed	One PMRT completed on 3 September; A/A grading.							Domestic abuse enquiry documentation reminder and family debrief.
Findings of all cases eligible for MNSI referral				MNSI case MI-061844 ongoing	No new eligible case identified in supplied deck	No new MNSI-eligible September case identified; existing MNSI case awaiting draft report.							Maintain tracking.
Patient safety incidents logged and actions taken				New moderate/death events reviewed; weekly governance review	Term stillbirth added; PSR/DOC in draft	Nine new moderate/severe events; PSRs, audits and local reviews initiated.							Missed Anti-D requires SABRE/SHOT reporting.
Training compliance across all maternity staff groups				Recovery actions and extra dates in place	Mandatory compliance below target in several groups	ESR data available; several measures below target; fetal monitoring 90%; anaesthetic PROMPT 86%.							Recovery dates and individual follow-up active.
Minimum safe staffing, obstetric cover and rota gaps				Maternity acuity pressure; neonatal QIS 49.9%	Maternity day fill 59.5%; neonatal BAPM 96.7%, QIS 49.9%	Red flags 66; LW acuity 60%; JM acuity 36%; midwifery day fill 55.1%; MSW night fill 36.6%; vacancy 6.61%.							Significant deterioration requires oversight.
Service user voice feedback themes				Compassionate care; communication and partner/estates issues	8 compliments; concerns about communication, documentation and care	One complaint, two Datix/Plaudit compliments and four complaints in progress; MNVP							Themes include communication, triage/ward care and

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Metric	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Quarterly note
						cards not effectively captured.							retained placenta.
Staff feedback from frontline champions and walkabouts				Estates and EPIC concerns	Acuity, staffing, skill mix and North Devon impact	Acuity, staffing, North Devon impact, estates and EPIC raised.							Actions in progress.
External concern or request for action from MNSI/NHSR/CQC/other				Regional concern on CO monitoring evidence	MNSI case remains active; CO data concern continues	Missed Anti-D is SABRE/SHOT reportable; three new risks added.							Maintain external and internal reporting.
Coroner Regulation 28 issued directly to Trust				Nil reported	Nil reported	Nil reported.							Routine monitoring.
Progress with applicable MIS/CNST safety actions				Evidence collation and MOSS planning	Training main risk; MOSS rescheduling prioritised	Training recovery and MOSS drill planning reported.							Training remains principal MIS risk.

Annual measures - not reported this Quarter

Measure	Reporting point	Latest result	Interpretation / action
Proportion of midwives agreeing or strongly agreeing they would recommend the Trust as a place to work or receive treatment	Not supplied / not applicable	Not supplied / not applicable	Not supplied / not applicable
Proportion of O&G specialty trainees rating out-of-hours clinical supervision as excellent or good	Not supplied / not applicable	Not supplied / not applicable	Not supplied / not applicable

Appendix 2. Supporting evidence and references

Section	Evidence source / report	Reporting period	Owner	Link / document reference
Executive summary / all sections	PQOM August (July Data).pptx	July 2026	Perinatal Quality Oversight	Supplied source deck
Executive summary / all sections	PQOM September (August Data).pptx	August 2026	Perinatal Quality Oversight	Supplied source deck
September available data	PQOM October (September Data).pptx	September 2026	Perinatal Quality Oversight	Supplied source deck

Section	Evidence source / report	Reporting period	Owner	Link / document reference
Workforce	BirthRate+, safer staffing and rota data in PQOM	Q2 2026/27	Operational leads	Embedded in PQOM decks
Incidents and learning	Datix / PSR / PSII / MNSI / PMRT summaries	Q2 2026/27	Clinical Governance	Embedded in PQOM decks
Service user insight	Complaints, concerns, compliments, MNVP and Safety Champions feedback	Q2 2026/27	Experience leads	Embedded in PQOM decks
Training	ESR, PROMPT, fetal monitoring and simulation updates	Q2 2026/27	Education Lead	Embedded in PQOM decks
Guidance	Guideline tracker summary	Reviewed 6 October 2026	Clinical Effectiveness	Embedded in October PQOM deck

Appendix 3. Glossary

Term	Definition
ATAIN	Avoiding Term Admissions into Neonatal units
BAPM	British Association of Perinatal Medicine
BI	Business Intelligence
CMBL	Cumulative measured blood loss
DOC	Duty of Candour
HIE	Hypoxic-ischaemic encephalopathy
MCB	Maternal Care Bundle
MIS	Maternity Incentive Scheme
MNVP	Maternity and Neonatal Voices Partnership
MNSI	Maternity and Newborn Safety Investigations
MOSS	Maternity Outcomes Signal System
PMRT	Perinatal Mortality Review Tool

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Maternal Care Bundle – TSDFT Implementation Plan

Executive Summary

The Maternal Care Bundle (MCB), published in January 2026, sets out evidence-based interventions across five clinical domains to reduce maternal mortality, morbidity and inequalities.

This implementation plan outlines the Trust's approach to:

- Achieving full implementation of all MCB interventions by March 2027
- Embedding robust governance, assurance and reporting mechanisms
- Delivering measurable improvements in clinical practice and outcomes

The Trust Board is asked to:

- Approve the implementation approach and supporting governance and reporting framework
- Endorse trajectories to full compliance
- Agree oversight via quarterly reporting

Scope

The plan covers implementation of all five MCB elements:

1. Venous Thromboembolism (VTE)
2. Pre-Hospital and Acute Care
3. Epilepsy in Pregnancy
4. Maternal Mental Health
5. Obstetric haemorrhage

In total, this comprises 14 interventions requiring full compliance.

Aims and Objectives

Aim

To achieve safe, equitable and evidence-based maternity care through full implementation of the MCB.

Objectives

- Establish a baseline assessment of compliance across all interventions
- Deliver SMART improvement actions for partially or non-implemented areas
- Ensure all minimum evidence and LMNS requirements are met for full compliance
- Embed routine data capture, performance monitoring and reporting
- Provide assurance to Trust Board and regulators

Implementation Approach

Phase 1 – Baseline and Gap Analysis (Q1-Q2 2026/27)

- Complete self-assessment using evidence worksheets
- Benchmark current practice against MCB standards
- Identify gaps in compliance and variation
- Validate position through clinical and governance review

Outputs

- Baseline compliance rating for all interventions (Fully Implemented/Partially Implemented/Not Implemented)
- Initial risk and gap register

Phase 2 – Planning and Trajectory Setting (Q3 2026/27)

- Develop detailed SMART action plans for each intervention not fully implemented
- Define trajectories to March 2027 compliance
- Identify resource, workforce and training requirements
- Align plans with:
    - LMNS priorities
    - Maternal Medicine Network (MMN) pathways
    - Integrated Care Systems (ICS) partners where required

Outputs

- Board- approved implementation trajectories
- Consolidated Trust wide MCB action plan

Phase 3 – Delivery and Embedding (Q4 2026/27)

- Implement improvement actions across all five elements
- Ensure:
  - Policies, SOPs and pathways are all updated
  - Training and competency compliance
  - Integration with electronic systems and dashboards
- Strengthen cross-speciality pathways (e.g. neurology, ED, mental health)

Outputs

- Progressive increase in fully implemented interventions
- Evidence mapped within the implementation tool

Phase 4 – Monitoring, Assurance and Sustainability (Ongoing)

- Quarterly update of:
  - Evidence worksheets (performance and data)
  - Action plans (progress and escalation)
- Board validation of implementation status
- Routine monitoring via:
  - Board summary dashboards
  - Quality governance structures

Outputs

- Quarterly Board assurance
- Sustained compliance 100% across all interventions

<u>Governance and Oversight</u>

Trust Responsibilities

- Develop and deliver implementation plan
- Report progress to the Trust Board regularly
- Escalate risks where trajectories are not met

Governance Structure

- **Executive Lead:** Chief Nurse

- **Programme Leads:** Director of Midwifery and Child Health & Perinatal Compliance Lead
- **Governance Groups:**
  - Trust Board
  - Quality People Committee
  - Perinatal Safety Champions Committee
  - Care Group Governance
  - Perinatal Governance Committee
  - Perinatal Assurance Meeting
- **Reporting:**
  - Monthly Internal Review- Discussed and reviewed within Perinatal Assurance Meeting and then communicated to Perinatal Governance Committee and escalated if necessary
  - Quarterly Board Report

Performance Management and Reporting

Key Measures

- Percentage of Interventions:
  - Fully implemented
  - Partially implemented
  - Not implemented
- Process and outcome metrics per element (see implementation tool)

Reporting Mechanisms

- Use of MCB implementation tool outputs:
  - Board Summary – Implementation
  - Board Summary – Action Plans
  - Progress and Board Review Record

Compliance Thresholds (for Board oversight)

- 100% - Fully Implemented – Fully compliant
- 80%-99% – Improvement required
- <80% – Escalation required

Risk Management

Key risks and mitigations:

Risk	Impact	Mitigation
Workforce capacity constraints	Delay in implementation	Workforce planning, training prioritisation
Cross-organisational pathway gaps	Fragmented care	Strengthen ICB / MMN partnership working
Data quality limitations	Reduced assurance	Implement standardised data collection
Training non-compliance	Patient safety risk	Mandatory training tracking and escalation

Stakeholder Engagement

- Internal:
  - Obstetrics, Midwifery, Anaesthetics
  - Emergency and Acute Care
  - Haematology, Neurology, Blood Transfusion Department
  - Mental Health Service
- External
  - ICB partners (to include liaison with Primary Care and SWAST)
  - Maternal Medicine Network
  - NHS England regional team

Timeline (High Level)

Phase	Timeline	Milestone
Baseline Assessment	Q1-Q2 2026/27	Completed self-assessment
Planning & Approval	Q3 2026-27	Board sign off of plan
Implementation	Q4 26/27	Progressive delivery
Full Compliance Target	March 2027	100% fully implemented
Ongoing Assurance	Quarterly	Board reporting

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Board Assurance

This plan provides assurance through:

- Structured baseline, action planning and review cycle
- Defined compliance threshold and trajectories
- Robust evidence-based validation process
- Alignment with national guidance and reporting expectations

Recommendations

The Board is requested to:

1. Approve the Maternal Care Bundle Implementation Plan
2. Agree the governance and reporting framework
3. Endorse trajectories to achieve full compliance by March 2027
4. Support organisational prioritisation of delivery

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Maternal Care Bundle

Governance and Reporting Framework

Supporting the TSDFT MCB Implementation Plan

Document Status	Draft for approval
Accountable Executive	Chief Nurse
Programme Leadership	Director of Midwifery and Child Health & Perinatal Compliance Lead
Review Cycle	Monthly Programme review; Quarterly Board assurance

Purpose

This framework defines the governance, accountability, reporting, validation, risk escalation and assurance arrangements required to oversee implementation and sustained delivery of the Maternal Care Bundle across all five clinical domains and 14 interventions.

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1. Framework Objectives

- To maintain a single, validated view of implementation status across all MICB interventions.
- To ensure that actions, risks, dependencies and evidence are owned, monitored and escalated consistently.
- Provide clear operational oversight, executive accountability and quarterly Board assurance.
- Demonstrate that reported compliance is supported by current, auditable evidence and measurable outcomes.
- To imbed improvement so that compliance is sustained beyond initial implementation.

2. Governance Principles

Principle	Application
Clear accountability	Each intervention has a named clinical lead, midwife and executive route for escalation.
Evidence before assurance	No intervention is reported as fully implemented without validated evidence against the implementation tool.
Proportionate escalation	Exceptions are escalated according to impact, trajectory, patient safety risk and delivery confidence.
Integrated oversight	MCB delivery is aligned with existing perinatal, care group, quality and Board governance structures.
Equity and outcomes	Reporting considers variation, inequalities, experience, process reliability and clinical outcomes.
Sustainability	Controls, training, audit and data collection become business as usual rather that time limited project activity.

3. Governance structure and accountability

Level / Forum	Core Role	Minimum Reporting Frequency	Key Output / Decision
Trust Board	Receives strategic assurance; approves the implementation approach, trajectories and material recovery plans	Quarterly	Assurance rating, decisions, support and challenge.
Quality People Committee	Provides detailed committee oversight of quality, safety, workforce, risk and delivery confidence before Board reporting.	Quarterly	Committee assurance and escalation to Board.

Executive Lead: Chief Nurse	Executive accountability; resolves barriers beyond programme authority and sponsors escalation.	Monthly and by exception	Executive direction, resource decisions and risk acceptance/escalation
Perinatal Safety Champions Committee	Reviews safety implications, barriers, themes and progress requiring multidisciplinary or executive influence	Bi-monthly	Safety challenge and recommendations
Care Group Governance	Provides divisional oversight of delivery, resources, risks and cross-speciality dependencies	Monthly	Care group assurance and escalation
Perinatal Governance Committee	Receives formal programme assurance; scrutinises compliance, evidence, outcomes and risks and overdue actions.	Monthly	Validated assurance position and escalations.
Perinatal Assurance Meeting	Detailed programme review of evidence worksheets, action plan, milestones, metrics and exceptions.	Monthly	Updated dashboard, action tracker and risk position.
MCB element / intervention leads	Deliver actions, maintain evidence, interpret performance and identify emerging risk.	Monthly / more often during recovery	Intervention update, evidence pack and recovery actions.

4. Accountability Matrix (RACI)

R = Responsible, A = Accountable, C = Consulted, I = Informed.

Activity	Board	QPC	Executive Lead	Programme Lead	Governance Forums	MCB Leads
Approve framework and overall trajectory	R	C	A	C	I	I
Maintain consolidated implementation plan	I	I	A	R	C	C
Deliver intervention actions	I	I	A	C	C	R
Validate evidence and status	I	C	A	R	R	C
Monitor metrics and inequalities	I	C	A	R	R	R
Maintain risks and escalate exceptions	I	C	A	R	R	A
Approve material recovery plans	R	C	A	C	C	C
Submit quarterly assurance report	I	C	I	R	C	A

5. Reporting and Assurance Cycle

Stage	Timing	Required Activity	Control
Data and evidence cut off	Working day 5	Intervention leads update metrics, evidence worksheets, action status, risks and dependencies	Evidence dated, version controlled and traceable to source
Programme quality check	Working days 6-8	Programme lead checks completeness, data quality, narrative consistency and overdue actions	Exceptions returned to owner before formal review
Monthly assurance review	By working day 10	Perinatal Assurance Meeting challenges status, trajectory, risk and recovery plans	Decision and rationale recorded in review log
Governance ratification	Next available monthly meeting	Perinatal Governance Committee confirms or amends the assurance position and escalations	Minutes record accepted status and required action
Care group / executive escalation	Monthly or urgent by exception	Material barriers, resource gaps or patient safety concerns are referred for decision	Named decision owner and deadline
Committee and Board reporting	Quarterly	Consolidated report to Quality People Committee and Trust Board	Position reconciled to the latest validated monthly dataset

6. Minimum Monthly Dashboard and Quarterly Report Content

Section	Minimum Content
Headline assurance	Overall RAG, direction of travel, delivery confidence and concise executive narrative
Implementation Status	Number and percentage of interventions fully, partially and not implemented, by MCB element
Trajectory	Actual versus planned position, forecast date, slippage and recovery milestones
Actions	Due, completed, overdue and at-risk actions; oldest overdue action; owner and revised date
Evidence Assurance	Evidence complete, evidence awaiting validation, evidence gaps and date last validated
Performance and Outcomes	Agreed process and outcome measures per element, including run/SPC charts where appropriate
Quality and Inequalities	Variation by relevant population or pathway, patient experience themes and unintended consequences
Workforce and Training	Training/competency compliance, capacity constraints and key staffing dependencies
Policies, SOPs and Pathways	Updates to each as progress is made within each element. Timescales, delays and issues highlighted.
Risks and Issues	Top risks, controls, residual score, trend, risk register reference and decisions required
Decisions and Asks	Explicit decision, accountable decision-maker and required date.

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7. Status Definitions and Escalation Triggers

Status	Definition	Required Response
Green / Fully Implemented	Implementation requirements are met, evidence is current and validated, and controls are operating	Continue routine monitoring and sustainability audit
Amber / Partially Implemented	Some requirements or evidence remain incomplete, but a credible funded trajectory and recovery plan are in place	Monthly recovery monitoring; escalate if trajectory deteriorates
Red / Not Implemented or Off Track	Material requirements are unmet, patient safety or delivery confidence is affected, or the agreed trajectory is unlikely to be achieved	Immediate recovery plan and escalation through executive and governance route
Grey / Not Assessable	Data or evidence is insufficient to support a reliable rating	Treat as an assurance gap; assign owner and rapid resolution date

Mandatory Escalation Triggers

- A patient safety concern or control failure requiring urgent action
- A red-rated intervention or forecast failure against the March 2027 target date
- A milestone missed without an approved recovery plan
- An action overdue by more than one reporting cycle, or repeated slippage
- Evidence unavailable, out of date or not independently validated
- Material workforce, training, digital, cross-organisational or data quality dependency
- A risk above the agreed local tolerance or requiring addition to the corporate risk register

8. Evidence Validation and Change Control

Control	Requirement
Evidence Standard	Evidence must be specific, current, attributable, accessible and mapped to the relevant intervention requirement
First-line Confirmation	The intervention lead confirms implementation and provides the underlying evidence
Second-line Validation	The programme lead and relevant governance/clinical reviewer test completeness and consistency before status changes
Status Change Approval	Movement to fully implemented is recorded in the Progress and Board Review Record with date, rationale and approver
Document Control	Evidence worksheets, dashboards and action plans use consistent version numbers, review dates and named owners
Audit Trail	Previous ratings, rationale, actions and evidence references are retained
Periodic Deep Dive	Each MCB element receives a themed review at least annually, or sooner when performance deteriorates

9. Risks and Issues Management

The programme risk register should include the risk description, cause, consequence, inherent score, controls, residual score, owner, review date, trajectory, linked action and escalation route. The draft plan identifies workforce capacity, cross-organisational pathway gaps, data quality limitations and training non-compliance as core risk themes.

Risk Theme	Routine Control	Escalation Evidence
Workforce Capacity	Workforce plan, protected delivery time and prioritised training	Vacancy/capacity impact, delayed milestone and requested decision
Cross-organisational Pathways	Named partner leads, agreed pathway actions and dependency log	Unresolved interface, patient impact and executive/ICB/MMN ask
Data Quality	Defined metric specification, source, owner, validation and completeness checks	Missing or unreliable data preventing assurance
Training Compliance	Named cohort, denominator controls, trajectory and exception handling	Persistent gap, safety impact or inability to release staff

10. Forward Reporting Schedule

Frequency	Product	Primary Recipient	Owner
Monthly	MCB implementation dashboard, action tracker, evidence exception report and risk register	Perinatal Assurance Meeting; Perinatal Governance Committee; Care Group Governance	Programme Lead
Quarterly	Board assurance report and summary dashboard	Quality People Committee and Trust Board	Executive Lead / Programme Lead
By Exception	Urgent escalation briefing and recovery plan	Executive Lead and relevant governance chair	Programme Lead / MCB Lead
Annually	Sustainability review and framework effectiveness review	Perinatal Governance Committee and Quality People Committee	Programme Lead

11. Standard Quarterly Assurance Report Template

1. Purpose – State the reporting period and the assurance/decision sought
2. Executive Summary – Overall status, direction of travel, delivery confidence, key achievements and principal concerns
3. Implementation Position – Status by element and intervention; actual versus trajectory; forecast compliance

4. Performance and Impact – Process, outcomes, balancing and equity measures; significant variation
5. Action Delivery – Completed, on-track and at-risk actions; recovery progress
6. Evidence and Validation – Evidence completeness, validation outcomes and unresolved assurance gaps
7. Risks and Dependencies – Top risks, changes in score, controls, external dependencies and requested support
8. Decisions Required – Specific decisions, owners and deadlines
9. Overall Assurance Statement – Suggested wording: "The Committee/Board can take [substantial/moderate/limited] assurance that implementation is progressing in line with the agreed trajectory, subject to the exceptions set out in this report."

12. Immediate Actions to Operationalise the Framework

Action	Owner	Target Point
Confirm named executive, programme, element and intervention leads	Programme Lead	At framework approval
Approve metric definitions, evidence standards and reporting cut-off	Programme Lead / Governance Leads	Before 1st monthly cycle
Establish a single controlled action tracker, risk register and evidence index and utilise the dashboard	Programme Lead	Before 1st monthly cycle
Agree a meeting sequence and report timetable across assurance, governance committee and Board routes	Programme Lead / Governance team	At framework approval
Complete baseline validation and record the initial assurance positions	MCB Leads / Programme Lead	In line with 1st phase
Set intervention trajectories and recovery triggers to March 2027	Executive and Programme Lead	In line with phase 2
Schedule quarterly Board reports and annual sustainability review	Governance Team	At framework approval

13. Lessons Learned and Benefits Realisation Review

Following full implementation, post March 2027, a formal lessons learned and benefits realisation review will be undertaken to evaluate the effectiveness, sustainability and impact of the Maternal Care Bundle programme. The review will assess delivery against the agreed objectives, performance measures and expected benefits, including improvements in patient safety, clinical practice, workforce capability and service quality. Key learning, areas for improvement and any unintended consequences will be identified to support continuous improvement and organisational learning. Findings and assurance regarding the sustainability of the implemented interventions will be

reported through the appropriate governance structure and presented to the Trust Board for assurance that improvements have been embedded within business-as-usual practice.

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Quality People Committee

Title: Perinatal staffing Report (1 January 2026 – 30 June 2026).

Presented to:	**Quality People Committee**			
Title of Report	**Perinatal Staffing Report January 2026 – June 2026**			
Date of Meeting	**22 September 2026**	**Author**	**Head of Midwifery & Gynaecology – Maria Mortimore** **Interim Inpatient Maternity Matron – Ceri Finch**	
Executive Lead	**Nicola McMinn - CNO**	**Executive Sign Off**	Nicola McMinn - CNO	
Governance Route	Metrics contained within this report have been presented at the monthly Maternity Governance and Service Meeting as well as at the monthly Maternity and Gynaecology Quality Meeting. The data is also shared as a slide set for the monthly Families and Communities Care Group Governance Meeting. Escalation of concerns will be via this route and/ or via the quality and performance assurance meeting.			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		x	x	
Executive Summary	This report gives a summary of all measures in place to ensure safe perinatal staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians, anaesthetics and neonatal medical and nursing staffing to provide evidence for the maternity incentive scheme year 8. The guidance recommends that the maternity establishment is reviewed at Board level at least every 6 months. The Quality People Committee are requested to note the following key issues: • The birth to midwife ratio falls well within the national recommendation of 1:28 • Good position in relation to % of women receiving one-to-one care in labour. • The Obstetrics & Gynaecology medical workforce continues to experience capacity issues, although this is an improving picture following support being provided by the Trust and impending recruitment.			

<table>
<tr><td></td><td colspan="6">• The expected fall in the vacancy rate for registered midwifery staff.
• The neonatal workforce continues to experience challenges in achieving full compliance with BAPM QIS staffing standards; however, progress has been made through targeted recruitment, workforce development, QIS training and implementation of a comprehensive workforce action plan aimed at improving resilience and long-term sustainability</td></tr>
<tr><td>Recommendation</td><td colspan="6">The committee is asked to receive and note this paper.

• Note the mitigations taken within the maternity service to ensure safety and quality.
• Note the ongoing service requirements of the Obstetrics and Gynaecology consultant team.
• Note the slight downwards trajectory in sickness rates within maternity staff and the mitigations being taken to support staff and reduce sickness absence levels.
• Note the expected fall in vacancy rate for midwifery staff within the next reporting period
• Note the contents of the report and formally record to the Trust Board minutes compliance with BAPM standards for the neonatal medical workforce and agree to the action plan for neonatal nurse staffing in relation to QIS nurses in SCBU.</td></tr>
<tr><td rowspan="2">Link to Strategic Signature Moves</td><td>Living well in our neighbourhoods</td><td>Reimagining acute and specialist care</td><td>Caring, skilled people ready for tomorrow</td><td>Joined up care, every step of the way</td><td>Smart use of technology for better care</td><td>Foundation</td></tr>
<tr><td></td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td colspan="6">This report describes how staffing and acuity levels are managed within the maternity and neonatal service to ensure that care is provided that is both safe and of a high quality for the pregnant population and their families in Torbay and South Devon. It supports the Trust strategy but ensuring optimum workforce numbers are enabled to deliver collaborative care as well as describing ways in which the workforce will adapt to support innovations in practice and workforce roles. It also describes the mechanisms that are in place that monitor these levels and actions taken to ensure these are maintained.</td></tr>
<tr><td colspan="7">Board Assurance</td></tr>
<tr><td>BAF Ref</td><td colspan="2">Principal Risk</td><td>Current Score</td><td colspan="3">Impact of this paper</td></tr>
<tr><td>Quality and Patient</td><td colspan="2"></td><td></td><td colspan="3"></td></tr>
</table>

Experience: Personalised Care People Strategy and Transformation					
Link to CQC Quality Statement	x		X	x	x
Link to CQC Quality Statement Compliance / Regulatory Requirements	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
Ethical or EDI implications?	Adequate workforce capacity is essential to ensure safe, personalised and equitable care for all women, babies and families. Workforce shortages may disproportionately affect vulnerable populations and increase risks to quality, safety and staff wellbeing. Ongoing workforce planning, recruitment, retention and flexible employment approaches are therefore critical to supporting both patient outcomes and workforce inclusion.				
Assurance rating	Moderate assurance is proposed due to static vacancy rate as well as improving trajectory in the QIS neonatal nursing ratio				
Assurance rating Assurance rationale	Significant	Moderate	Limited	Inadequate	
		x			
Appendices	Appendix 1 – Neonatal workforce action plan *The appendix is in the Items for Information Pack*				

1.0 Introduction

This report covers the period from 1 January 2026 to 30 June 2026 and details compliance with the standards set out in national and regulatory frameworks (as set out below).

2.0 Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate midwifery staffing paper is provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

3.0 Midwifery Staffing Establishment

3.1 Birthrate Plus® workforce planning

A formal Birth Rate Plus assessment was completed in September 2025 and the report published in October 2025, this reviewed the acuity of women who used maternity services at Torbay & South Devon NHS Foundation Trust. This review recommended a birth to midwife ratio of 34 births per whole time equivalent (wte) midwife across the Trust.

NICE (2017) recommend that an assessment is carried out every three years. The finalised report from the study undertaken in September 2025 evidenced that a 3.81wte uplift in midwifery staffing was required. The report has been presented to the Trust Board for their approval and decision regarding the level of staffing uplift that will be provided. A separate business case is required to progress the required uplift which at the time of writing this paper has been approved through the relevant processes.

3.2 Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient John Macpherson ante/postnatal ward by month:

Chart 1: Percentage fill rates for John Macpherson Ward

Month	Day Registered %	Night Registered %	Day Unregistered %	Night Unregistered %
Jan 2026	71.2	77.6	92.0	101.5
Feb 2026	79.7	89.2	95.2	80.6
Mar 2026	84.1	86.3	90.3	74.2
Apr 2026	79.3	99.9	94	76.7
May 2026	76.7	96.8	79.9	71.1
Jun 2026	77.8	95.5	91.4	80.0

Following review of the acuity data provided by the Birthrate Plus acuity tool, it was evident that occasions of staffing levels across the service not meeting with acuity levels were predominantly occurring on John Macpherson Ward overnight. For this reason, priority was given to fill rates on the ward overnight and this is evidenced by the increase in fill rates for registered staff overnight in the table above.

Fill rates are monitored daily, and staff redeployed based on the acuity. When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- 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 midwifery matrons.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, bank hours and staff working extra hours have been used across the service to cover maternity leave, vacancies and long and short-term sickness.

3.3 Recruitment

Chart 2: Vacancy Rates and Maternity Leave in Maternity Service



Month	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Overall vacancy rate	2.697	2.777	3.177	4.577	4.017	4.017
Maternity leave	2.81	1.81	2.71	2.62	3.62	5.47

During this 6-month reporting period there has been a slight rise in the monthly vacancy rate from 2.697wte in January to 4.017wte in June 2026. Whilst this remains a low vacancy rate for the service, this is expected to reduce further in the next reporting period when the current set of preceptee midwives will complete their preceptorship year in September 2026.

The maternity service had previously transferred existing Band 6 establishment to increase the establishment of Band 5 preceptee midwife posts from 5.4wte to 6.4wte for a 12-month period between September 2025 to September 2026. These are 12-month fixed term posts which support in growing the future workforce and readying newly qualified midwives for band 6 midwifery positions. The preceptee midwives are provided with support from the Education Midwives and receive additional support through inclusion in the Trust-wide preceptee programme. This temporary transfer in establishment was made to provide support with a regional shortage in available preceptee posts across the Southwest.

In this reporting period feedback was obtained from maternity staff regarding this increase in preceptee establishment. The team advised that there had been issues regarding the dilution of skill mix and challenges with providing support and supervision to an increased number of preceptees. For this reason, the decision was made to revert to the previous preceptee establishment of 5.4wte from September 2026.

3.5 Specialist Midwives

The Birth Rate Plus report from October 2025 recommended that 14.39wte of the total establishment are not included in the clinical numbers, this includes management positions and specialist midwives. For this reporting period there were 10.1wte specialist and management midwives in post for TSDFT, leaving a deficit of -4.29wte according to the BirthRate Plus recommendations. This gap was acknowledged within the diagnostic element of the Maternity Neonatal Improvement Support programme and formed part of the recommendations in the ongoing improvement plan for perinatal services.

3.6 Birth to Midwife Ratio

The midwife to birth ratio data provides further insight into maternity workforce models and staffing levels. The ratio is calculated by dividing the total number of births by the whole-time equivalent number of midwives. The calculation is crude, as it only considers births and not the impact of all the other activity/acuity. It also does not include gaps in establishment caused by sickness, maternity leave and staff working amended duties. The current national recommendation is a ratio of 1:28 midwives.

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

TSDFT maternity services currently utilise the Birthrate Plus (BR+) acuity tool on Labour Ward and use the antenatal and postnatal BR+ acuity tool on John Macpherson Ward, to provide a more detailed day to day reflection of the acuity within the service.

Chart 3: Midwife to Birth ratio (exc. DOM, HOM, Matrons and Specialist roles)

Time period	Midwife: Birth Ratio
Jan 26	1:18
Feb 26	1:19
Mar 26	1:16
Apr 26	1:17
May 26	1:22
Jun 26	1:22

4.0 Women receiving one-to-one care in established labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to take actions. These may be clinical, or management actions taken.

Unfortunately, due to current limitations within the EPIC EPR system, we are unable to obtain this data for April to June 2026. A request has been logged, and this data should be available for the next reporting period.

Chart 4: Percentage of women receiving one-to-one care in labour

Time period	%
Jan 26	100%
Feb 26	98.6%
Mar 26	100%
Apr 26	Data not available
May 26	Data not available
Jun 26	Data not available

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

5.0 Obstetric, Neonatal Medical & Neonatal Nursing Workforce

5.1 Obstetric workforce:

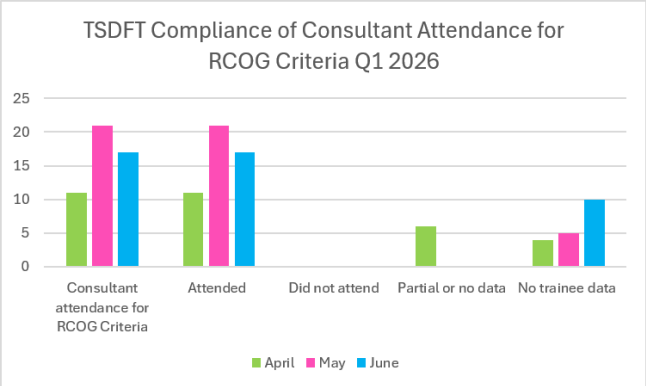
In 2025 the Trust Executive approved an uplift of two consultant posts, and two new consultants were recruited. However, due to the retirement of an existing consultant, this resulted in only one new post being appointed to, as the other covered the consultant that had resigned. Further approval was received within this reporting period to recruit to an additional consultant post, in addition to another two replacement posts following two further resignations, resulting in four consultant posts to be recruited to. Two of these four posts have now been recruited to, with the consultants having starting dates later this year and two further posts will be advertised.

The obstetric consultant team and maternity senior management team acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service. This includes obstetric staffing on the labour ward and any rota gaps.

The service monitors compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible are reviewed at unit level as an opportunity for

departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Chart 5: Consultant attendance audit – Quarter 1 2026



Actions taken because of this audit:

- Prompts ongoing in handover room
- Ensuring requirement for consultant attendance is included as part of induction
- Audit results and actions shared with Maternity Safety Champions and Quality People Committee

Maternity Services at TSDFT have implemented the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.

5.2 Neonatal medical workforce:

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

5.3 Neonatal nursing workforce:

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

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

Quarterly neonatal network workforce returns continue to be completed and submitted to the network for review and form part of a network response to NHSE regarding regional workforce and establishment.

5.3.1 **Workforce analysis:**

There remain challenges in achieving full compliance with BAPM neonatal nursing workforce standards, primarily due to limitations of Qualified in Specialty (QIS) nurses. (BAPM requirement 70% of direct care registered nurse workforce are QIS, current figure is at 59%). The neonatal service continues to experience workforce pressures associated with recruitment, retention, sickness absence, maternity leave and the time required to develop nurses through the recognised QIS educational pathway.

Quarterly workforce reviews demonstrate that, whilst the service remains below the recommended proportion of QIS nurses, there has been continued investment in workforce development and succession planning. Progress has been made through targeted recruitment, development of existing staff and establishment of a sustainable QIS training pipeline, providing a positive trajectory towards improved workforce resilience.

These challenges are consistent with those experienced across the Southwest Neonatal Network and nationally, where recruitment and retention of experienced neonatal nurses continues to present a significant workforce challenge.

Despite these workforce pressures, robust operational mitigations remain in place, including flexible deployment of skilled staff, utilisation of temporary staffing solutions where required, and senior clinical leadership support. These measures have ensured maintenance of safe service delivery and the ability to continue accepting internal neonatal admissions throughout the reporting period.

The workforce structure is also under review to ensure the establishment is responsive to both current and future service requirements, recognising increasing complexity, acuity and the need for sustainable workforce resilience.

5.3.2 **Compliance with BAPM Neonatal Nursing Standards:**

The neonatal nursing establishment is reviewed against the British Association of Perinatal Medicine (BAPM) Nurse Staffing Standards using the Neonatal Nursing Workforce Calculator (2020). Compliance with these standards is formally reported to the Trust Board on an annual basis as required by the Maternity Incentive Scheme.

The most recent workforce review identified ongoing challenges in achieving the required level of Qualified in Specialty (QIS) nursing provision, reflecting local, regional and national workforce pressures. Contributory factors include vacancy levels, maternity leave, long term sickness, retirement, and the time required to develop newly recruited neonatal nurses through the recognised QIS training pathway.

An action plan has been developed and continues to be monitored to address the identified workforce gaps. Key progress made during this reporting period includes:

- Successful recruitment of a Band 6 QIS nurse who commenced in June 2026.
- Continued investment in the QIS workforce pipeline, with one Band 5 nurse now achieving QIS status, a further nurse nearing completion, and additional staff identified for future cohorts.
- Review of the neonatal workforce establishment and organisational change proposals to ensure the future workforce model is sustainable and responsive to service demand and acuity.
- Ongoing mitigation through use of QIS bank staff, senior clinical leadership support and rostering measures to maintain operational resilience and safe staffing.
- Development of a leadership and workforce sustainability programme to support retention, succession planning and career progression within the neonatal workforce

Progress against the neonatal workforce action plan is monitored through local governance arrangements and reported through paediatric quality and safety structures. The action plan has been shared with both the Local Maternity and Neonatal System (LMNS) and the Neonatal Operational Delivery Network (ODN), with ongoing oversight provided through these forums.

The findings of the Neonatal Nursing Workforce Calculator (2020), associated compliance assessment and workforce action plan are presented through Trust governance arrangements and form part of the annual Board assurance process for Maternity Incentive Scheme Safety Action 4

5.3.3 **Neonatal Nursing Workforce Action Plan**

In accordance with Maternity Incentive Scheme requirements, a neonatal nursing workforce action plan is in place to address identified gaps against BAPM standards. The plan focuses on recruitment, retention, workforce redesign, QIS development, leadership development and operational resilience. Progress against actions is monitored through neonatal quality and safety governance structures and reported through paediatric governance arrangements. The action plan has been shared with the LMNS and Neonatal Operational Delivery Network (ODN), with ongoing oversight provided through these forums

5.4 Anaesthetic Workforce:

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

The following chart demonstrates compliance with this standard by month:

Chart 6: Anaesthetist availability for obstetric cover 24hrs/day

	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
% compliance	100%	100%	100%	100%	100%	100%

6.0 Maternity Red flags

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following chart demonstrates red flag events:

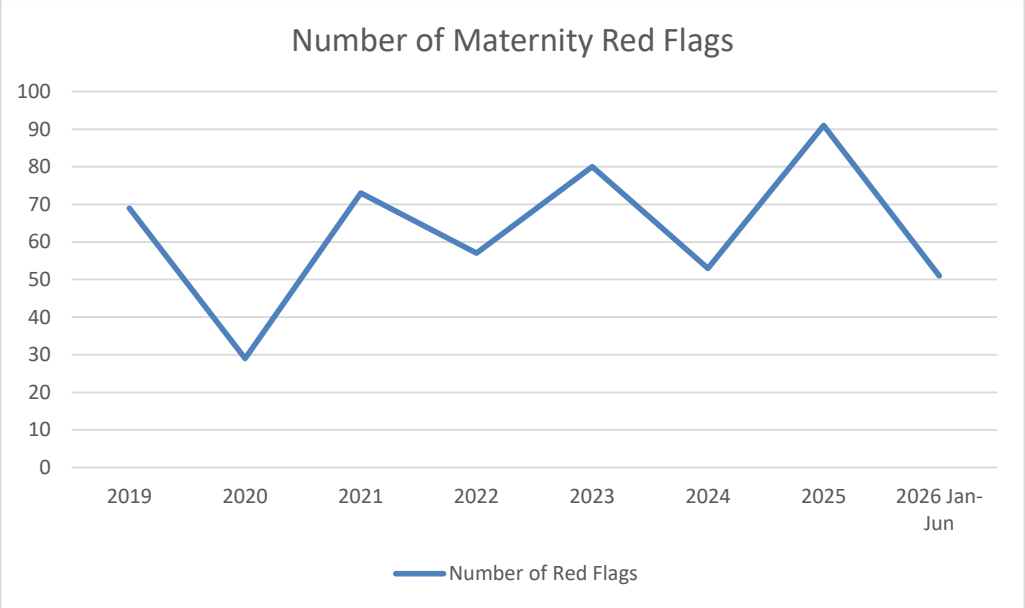
Chart 7: Maternity Red Flags

Red flag	Description	Incidence						
		Jan	Feb	Mar	Apr	May	Jun	Tot
RF1	Delayed or cancelled time critical activity	1	2	0	0	0	4	**7**
RF2	Missed or delayed care	0	1	0	0	0	4	**5**
RF3	Missed medication	0	0	0	0	0	0	**0**
RF4	Delay in providing pain relief	0	0	0	0	0	0	**0**
RF5	Delay between presentation and assessment	1	0	1	0	0	1	**3**
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0	**0**
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	2	3	0	0	3	2	**10**

RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**
RF9	1:2:1 care in labour	0	1	0	0	0	0	**1**
RF10*	Unable to facilitate out of hospital birth	3	3	2	0	0	1	**9**
RF11	Coordinator unable to maintain supernumerary status- providing 1:1 care in Labour	0	0	3	0	1	1	**5**
RF12	Coordinator unable to maintain supernumerary status - Not providing 1:1 care	1	0	3	0	3	4	**11**
	Totals	**8**	**10**	**9**	**0**	**7**	**17**	

Chart 8 Maternity Red Flag totals for previous years

Maternity Red Flags	Number
2019	69
2020	29
2021	73
2022	57
2023	80
2024	53
2025	91
2026 Jan-Jun	51



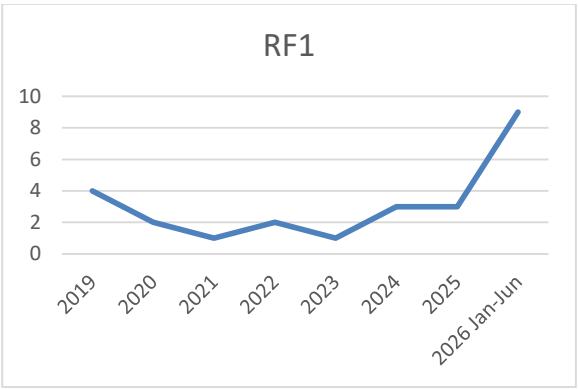
Red flags continue to occur predominantly during periods of high acuity. Each event is reviewed by the Maternity Matron and, where appropriate, with the Labour Ward Co-ordinator through the established governance process. This supports timely scrutiny, identification of contributory factors and appropriate action.

All red flags in this reporting period were raised appropriately through the service's proactive safety process, enabling operational risk to be identified and escalated during periods of pressure.

Acuity and red flag reporting compliance has averaged 73.4%, with no sustained improvement over the last seven years. Further work is required to strengthen daily reporting and understanding of its role in safe staffing, escalation and assurance.

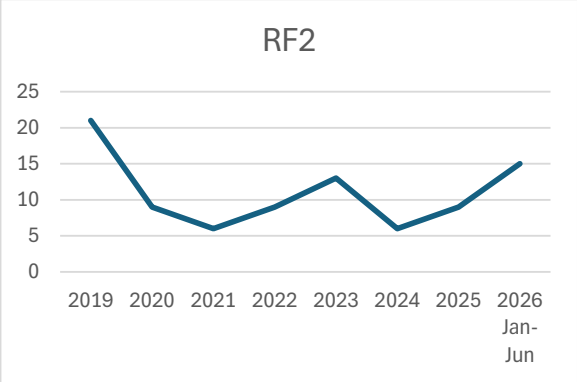
6.1 Individual review of Red Flags

Chart 9 Delayed or cancelled time critical activity (RF1)



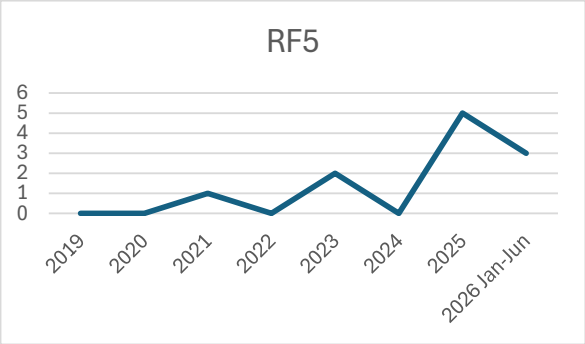
- Seven incidents were recorded. This represents a marked increase; however, most events occurred in June, when the service experienced staffing pressures alongside high acuity. Incidence remained low in the other months.
- Action: Continue individual review and strengthen staffing and escalation arrangements to reduce recurrence.

Chart 10: Missed or Delayed Care (RF2)



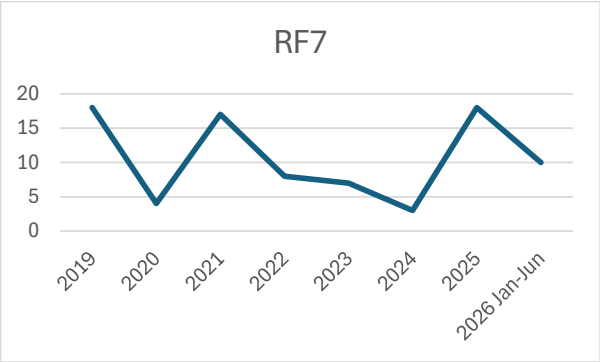
- Five incidents were recorded, representing a slight increase during this reporting period.
- Although not the highest-volume category, missed or delayed care remains an important safety indicator and may reflect competing clinical priorities.
- Action: Continue individual review and monitor the impact of workforce and escalation measures.

Chart 11: Assessment delays (RF5)



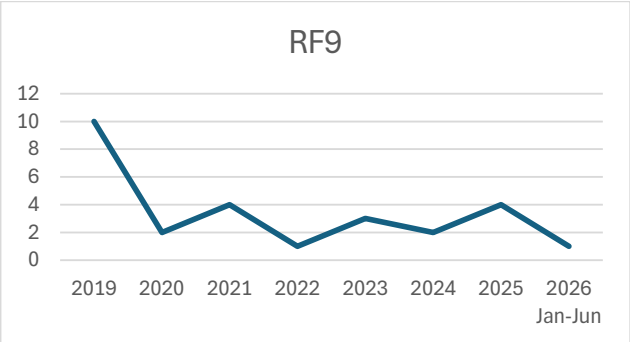
- Three incidents were recorded.
- Action: Continue to monitor this indicator as the maternity triage service develops, supporting timely assessment and escalation.

Chart 12: Persistent Pressure on Induction of Labour (RF7)



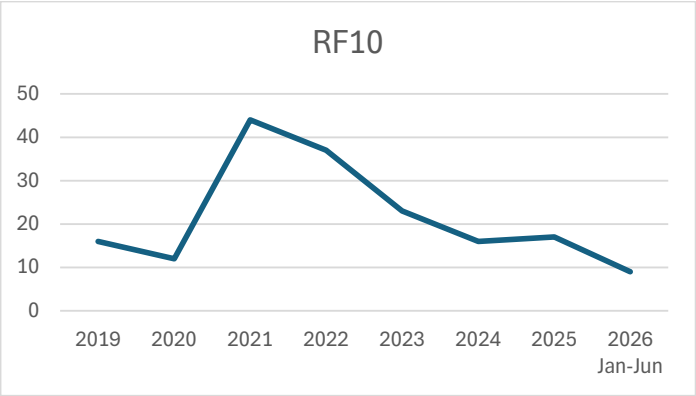
- Ten incidents were recorded, making it one of the largest contributors to the overall number of red flags.
- Contributory factors included:
  - Insufficient midwifery capacity to commence the induction process promptly.
  - High labour ward acuity, competing clinical priorities and bed capacity pressures affecting planned activity.
- Action: Review induction planning alongside elective caesarean activity and unpredictable spontaneous labour. A green, amber and red complexity rating is being considered to support balanced booking and avoid scheduling more than one complex induction on the same day.

Chart 13: Providing 1:1 care in labour (RF9)



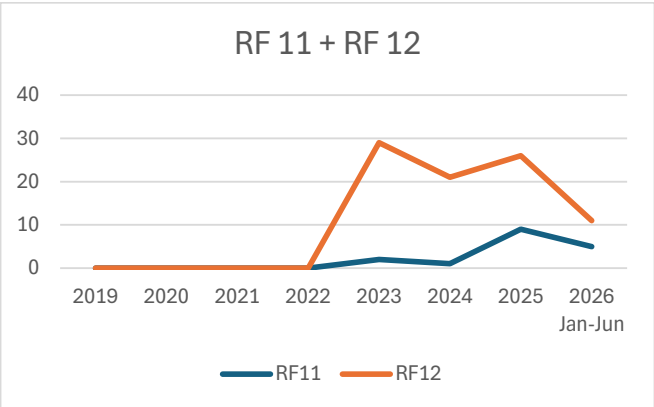
- One incident was recorded, consistent with previous years. The service remains committed to one-to-one midwifery care during established labour, in line with national safe staffing guidance.

Chart 14: Out-of-Hospital Birth Capacity (RF10)



- Nine incidents were recorded where the service was unable to facilitate an out-of-hospital birth.
- This reflects:
    - Staffing pressures limiting the safe deployment of integrated midwives away from the acute unit.
    - Impact on service user choice and experience, alongside a declining trend in planned out-of-hospital birth.
- Repeated inability to provide this pathway reinforces the need for sustainable workforce planning.
- Action: Service redesign is in progress to improve staff availability and deployment, supporting choice of place of birth wherever safe.

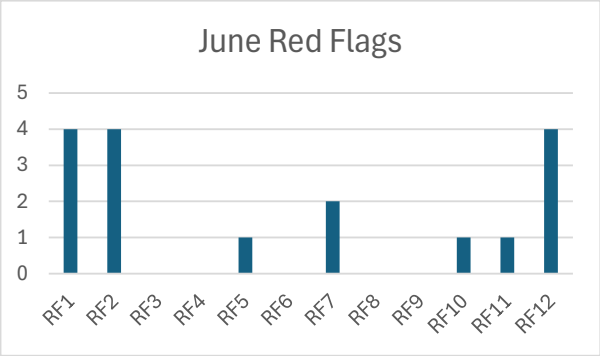
Chart 15: Increasing Difficulty Maintaining Supernumerary Coordinator Status (RF11 & RF12)



- Together, RF11 and RF12 accounted for 16 incidents.
    - RF11 (Coordinator providing 1:1 care): 5
    - RF12 (Coordinator not providing 1:1 care): 11
- This represents an important safety signal:
    - Labour Ward Co-ordinators were required to move from their supernumerary role to provide direct care.

    - Loss of co-ordinator oversight may reduce situational awareness, delay escalation and affect flow.
- Action: Short-term increases in acuity, particularly out of hours, remain challenging within a smaller workforce and without an on-call staffing escalation model. Service redesign is under way to improve workforce availability and deployment.

Chart 16: Rising Incidents in June



- June shows the highest monthly total (17).
- Principle contributory factors were:
    - Increased acuity and activity.
    - Sickness absence.

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

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

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

The ongoing ambition remains to achieve 100% supernumerary status for Labour Ward Co-ordinators. Chart 15 (above) demonstrates our compliance with this ambition for the period Jan to June 2026.

From March 2023, an additional red flag was introduced (RF12) to monitor compliance with supernumerary status when the Co-ordinator is caring for women who do not require constant observation, including break cover. This should not occur routinely. During the current six-month reporting period, eleven instances of this red flag were recorded. This is slightly fewer than the previous six months. The continued number of these red flags reflects temporary pressures in staffing from short term increases in acuity. The unpredictability of workload in an acute maternity setting means complete elimination of these occurrences is unlikely.

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

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

The service has progressed the development competency framework for aspiring LWC which enables experienced and competent Band 6 midwives to develop the nationally recognised capabilities to be able to take charge if required, in the unexpected absence of the LWC.

7.0 Birthrate Plus® Acuity Data

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

Staffing v Workload Example

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

The data for this period indicates that on labour ward staffing levels were classified as red <2% of the time during the reporting period (a red classification indicates that staffing was more than 2 midwives short) and that 17% of the time staffing levels were up to 2 midwives short (Amber). Therefore, staffing levels met the acuity levels 81% of the time.

On John Macpherson Ward staffing levels were red 33% of the time and staffing levels met the acuity levels 67% of the time.

Chart 17 – Labour Ward Staffing v Workload Jan-Jun 26'

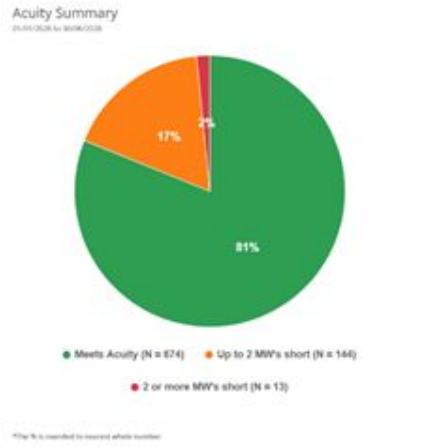
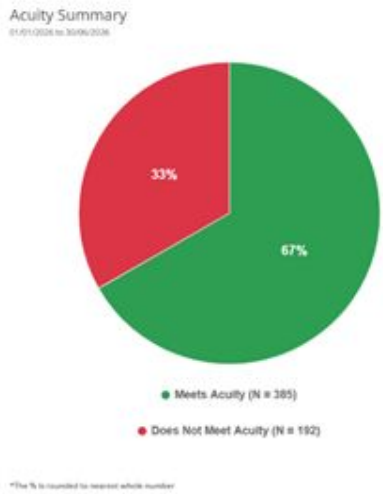


Chart 18 – John Macpherson Staffing v Workload Jan-Jun 26'



Staffing levels across the service met with acuity levels on most occasions (over 81% on Labour Ward and 67% on John MacPherson). On John MacPherson the majority of occasions where acuity exceeds staffing are due to staffing levels being one staff member short. The data and staffing pattern has been analysed and shows that most pressure occurs out of hours when staffing reduces whereas 'in hours' staffing often exceeds acuity. Maternity managers and ward managers had trialled the redeployment of exisiting staff members from a day shift to a night to help improve this. But recently, challenges have been found in staffing the night shifts. An improvement in this is planned by the current ongoing service re-design.

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

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

1. **Acuity scores are not directly comparable**
   A “high acuity” shift on a mixed ward may reflect sustained moderate needs across many patients rather than a small number of intense intrapartum cases.
2. **Staffing ratios differ**
   Labour ward ratios are based on one-to-one care in labour; mixed ward ratios must account for aggregate care hours across AN and PN categories, plus neonatal needs.
3. **Bed occupancy and turnover patterns**
   Mixed wards may appear “less acute” in headline scores but can be operationally busier due to constant admissions/discharges, multiple care pathways, and dual mother–baby dependency.
4. **Skill mix planning**
   Data should inform not just numbers of staff but the type, e.g. postnatal breastfeeding support, antenatal monitoring expertise, neonatal care skills

Staffing met acuity for most of the reporting period. Reoccurring short periods of unmet acuity were managed through escalation and mitigation processes.

Chart 19 Staffing factors, clinical and management actions- Labour Ward

Number of Staffing Factors

01/01/2026 to 30/06/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	X DO NOT USE	1	0%
SF2	Unexpected staff absence	97	17%
SF3	Staff on transfer	10	2%
SF4	Unable to fill vacant shifts	171	29%
SF5	No MCA support	87	15%
SF6	No Ward Clerk/Receptionist	92	16%
SF7	M/W out of hospital at birth	13	2%
SF8	M/W out of hospital at assessment	9	2%
SF9	Redeploy staff to other maternity area in hospital	65	11%
SF10	>2 preceptees in skill mix	2	0%
SF11	1 Midwife out in community supporting	30	5%
SF12	2 Midwives or more out in community supporting	9	2%
TOTAL		586	

*The % is rounded to nearest whole number

The above chart provides evidence of both the factors affecting the staffing v workload data and any actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

One of the highest recorded factors for staffing not meeting acuity is an inability to fill vacant shifts (SF4) 29%. This is relative to the levels of staff sickness. This was linked to sickness and was harder to mitigate during school holidays, when fewer staff undertook additional shifts.

Chart 20- Staffing factors, clinical and management actions- John Macperson

Number of Staffing Factors
01/01/2026 to 30/06/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	11	6%
SF2	Unexpected support staff absence/sickness	14	7%
SF3	Unable to fill vacant MW shifts	17	9%
SF4	Unable to fill vacant support staff shifts	11	6%
SF5	Staff on transfer duties	2	1%
SF6	MW redeployed to other area	26	14%
SF7	Support staff redeployed to other area	7	4%
SF8	Support staff less than rostered numbers	6	3%
SF9	No support staff available	0	0%
SF10	No Ward Clerk available daytime	21	11%
SF11	Unable to provide NIPE MW	75	39%
TOTAL		190	

*The % is rounded to nearest whole number

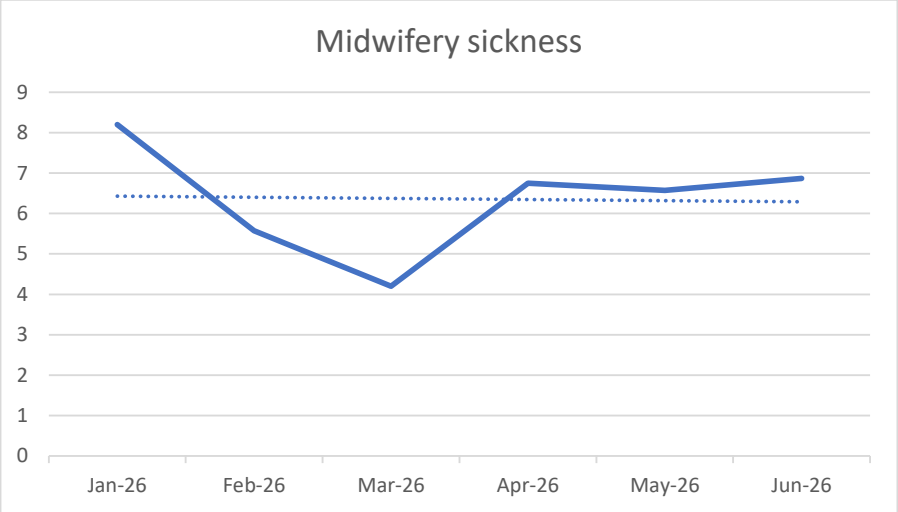
On John Macpherson Ward, it is noted that the largest factor (39%) was inability to provide a NIPE qualified MW. This is a concern as it impacts on patient flow with delayed discharges and causes redeployment of management/specialist midwives into the role of NIPE midwife. Newly qualified midwives are now entering the workforce with the NIPE qualification in place. As increasing numbers of midwives join our workforce with this qualification already in place, this number should drop significantly as NIPEs will be completed post birth before the newborn has left the Labour Ward.
The highest mitigation recorded on this reporting period was SF6 – MW redeployed to other area. This is a common action used by the Labour Ward Co-ordinator to maintain safety during times of high acuity. Moving staff from across the different departments to ensure safe care is provided where it is needed.

8.0 Sickness

Overall, the sickness rates within maternity have remained relatively static in this reporting period. Further investigation has shown that a large proportion of this was due to long term sickness, with the majority being attributed to medical reasons, although there did remain several staff on long term absence due to stress.

Targeted support is being provided to staff following long term absence, including Occupational Health referrals, flexibility and adaptations to working patterns to support staff with ongoing health needs and tailored phased return plans. In addition, the Education team are planning are planning to offer additional teaching support to staff returning following a long-term absence to help with any learning needs and the Professional Midwifery Advocates (PMAs) will be offering further support for staff during phased returns to work.

Chart 21: Midwifery Sickness Percentage



9.0 Escalation and Interventions to Assure Safety

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

As part of the maternity psychological safety strategy, feedback has been obtained from staff regarding what their needs are from an escalation plan. This feedback will form an integral part of the final plan. There will be a requirement for the service to develop a midwifery out of hours on call process within the coming months.

10.0 Conclusion

Challenges continue within the Consultant workforce in Obstetrics & Gynaecology, due to the retirement and resignation of several members of the team. Recruitment to several posts has taken place within this reporting period and advertising of the remaining vacant posts will take place later this year.

Whilst the overall vacancy rate for maternity staff has remained low, but relatively static, there is a significant fall in the rate expected within the next reporting period. This is due to the completion of the preceptorship year for the current preceptee midwives (6.4wte), who will then be able to apply for substantive posts within the service. This evidences the positive feedback that the maternity service has received, via NHS England, from midwifery students working within the service who have demonstrated a strong desire to secure a post within TSDFT's Maternity Services.

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

The finalised workplace establishment review report has recommended an uplift in registered maternity staff of 3.81wte and this is being progressed through governance and finance processes.

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

11.0 Assurance and Recommendations

Overall, there is a moderate level of assurance around the maternity and neonatal workforce metrics. This assurance level relates to the static vacancy rate within the Midwifery staffing levels, which is expected to fall to very minimal levels later in 2026. In addition, whilst there have been some resignations and retirements within the consultant body, there has been successful recruitment to posts with further recruitment planned imminently.

There is also moderate assurance in relation to the reduced ratio of QIS (Qualified in Speciality) nurses within SCBU due to the impact such ratios can have on the ability to staff the unit at optimal levels as well as impacting on the maternity service. Although the QIS ratio sits beneath the requirement, there has been improvement in this reporting period with sustainable plans in progress.

The Committee is requested to:

- Note the mitigations taken within the maternity service to ensure safety and quality.
- Note the ongoing service requirements of the Obstetrics and Gynaecology consultant team.

- Note the slight downwards trajectory in sickness rates within maternity staff and the mitigations being taken to support staff and reduce sickness absence levels.
- Note the expected fall in vacancy rate for midwifery staff within the next reporting period
- Note the contents of the report and formally record to the Trust Board minutes compliance with BAPM standards for the neonatal medical workforce and agree to the action plan for neonatal nurse staffing in relation to QIS nurses in SCBU.

The committee is asked to receive and note this paper.

The Committee are asked to agree the recommended assurance rating and take **Moderate** assurance for point 3.3 and 5.3.

Neonatal Workforce Action Plan									
Date	Action	Owner	Target	Status	Update inc date	Update inc date	Update inc date	Update inc date	Update inc date
01/11/2025	**Review of exisitng establishment structure to ensure it meets service needs now and for the future.**	ADNPP/Matron/Unit Manger	01/12/2026	In progress	1: Case for change consultation paper written with approval from Care Group. 2: Engagement with Strategic People Partner to support process 3:Formualtion of Band 3 Neonatal HCSW Job description in progress. (05/03/26)	**Update 24/08/26** 1: Draft consultation paper updated and with finance to provide updated costing figures. 2: Due to go to partnership board 23/09/26 3: Band 3 Job description has been matched and approved 19/08/26) 4: 25/26 network workforce return to be reviewed and analysed to support any further refinement to establishment structure.			
20/12/2025	**Recruitment - Seek support from attraction and recruitment team to bolster current strategy**	Matron/Unit Manager	30/04/2026	Completed	1:Meeting with attraction and recruitment team lead to discuss options 2: Adverts updated to reflect the unit culture and be more enticing 3: Explored options and costings for advert in RCNi for QIS 4. Comms sent to University programme leads to encourge soon to qualify nurses to apply for B5 vacancy (05/03/26)	**Update 11/06/26** RCNi option not persued after reviewing cost/benefit. 1WTE B6 QISrecruited and started in June. Some success with university comms and recruitment to B5 vacancy. Lines of communication with recruitment & attraction lead remain open.			
31/12/2025	**Approval for time limited incentive payment for substantive staff covering additonal duties to provide short term resilience for safe staffing numbers**	ADNPP/Matron	30/01/2026	Completed	1: Paper outlining challenges and costings prepared and shared with Chief Nurse 2: Approval from CNO and finance until 31/03/26 (05/03/2026)				
01/09/2025	**QIS pipeline - ongoing development of Neonatal Nurses**	Matron/Unit Manager	Ongoing	In progress	1: 2x Band 5 progressing with training on 25/26 QIS traing cohort - due to complete summer 2026 2: Further 2x Band 5 to be supported to attend 26/27 cohort 3: Recent recruitment of Band 5 - expectation to commence following compleiton of NFP.	**Update 24/08/26** 1: 1 B5 has passed QIS, with further candidate nearing completion of assessment. Both will need to be supported with a structured consolidtion plan. 2: 1 B5 joining 26/27 cohort in November 26 3: 4 new B5 commencing NFP with 2 strong candidates for 27/28 QIS cohort.			
01/09/2026	**QIS consolidation and leadership development framework (B5-B6)**	Matron/Unit Manager/Education Lead	31/12/2026	Not started					
01/09/2025	**Ongoing Mitigation for short notice abcence/vacancy/ long -term sicknessto ensure unit is operational**	Matron/Unit Manager	Ongoing	In progress	1: Use of QIS bank staff on NHSP 2: Practice Educator is currently in the clinical numbers 3: ENNP and Unit Manager cover on ad hoc basis (05/03/26)	**Update 24/08/26** Recent success with B5 recruitment is supporting more effective rostering of QIS to ensure consistent cover and robust rostering. 1 B5 advert currently out. B5 QIS due to return from mat leave spring 27			
02/03/2026	**Workforce organisational change - B4 Nursery Nurse to B3 Neonatal HCSW**	Matron/DOM	31/12/2026	In progress		**Update 24/08/26** 1: Draft consultation paper updated and with finance to provide updated costing figures. 2: Due to go to partnership board 23/09/26 3: Band 3 Job description has been matched and approved 19/08/26) **Directory of Midwifery now Senior Lead oversight for consultation.**			
05/03/2026	**Leadership development of team to support career development, retention and succession planning**	Matron/Unit Manager	31/03/2027	Not started	Link to MNP Culture & Leadership workstream action				
05/03/2026	**Foster a culture to enable supportive challenge and enhance psychological safety**	Unit Manager/Matron	31/12/2026	In progress	1: Engage SPP to establish what OD support is available 2: Contact Ben Hogan from OD team to formulate approach(05.03.26)	1: Healthy and Effective team survey distributed to all staff. Reponses are anonymous (10.06.26)			
05/03/2026	**Supporting staff to regularly access clinical supervision/Restorative Clinical Supervision**	Unit Manager/Matron	Ongoing	In progress	**Update 24/08/26** 2 staff on unit have completed PNA course and there are a further 3 within paeds and public health to support if a supervisor outside of the unit is more appropriate. Staff supported on an ad hoc basis to access in working hours with back/fill from unit manager/education. Active signposting by senior leadership team. PMA service also available to support the team as needed.				
01/07/2026	**Educator provision (vacancy)**	Unit Manager/Matron	31/10/2026	In progress	**Update 24/08/26** 1: Exisiting PE stepping down to clincal role - recruitment and ER contacted as evidence of recruitment process incomplete and advice sought how to proceed. 2: Revision of educator Job Description 3: Further request to finance to pull role out of direct care establisment. 4:Scoping of opportunity to meet unit requirements and offer development within education resource in paediatrics. PE in paediatrics has credible neonatal experience. Interim and permanent options being explored.				
				Not started					
				Not started					
				Not started					
				Not started					
				Not started					
				Not started					

NHS
Torbay and South Devon
NHS Foundation Trust

Presented to:	**Quality and People Committee**					
Title of Report	Patient Experience Annual Report 2025/26					
Date of Meeting	22/09/2026		**Author**	Head of Compliance and Assurance		
Executive Lead	Chief Nurse		**Executive Sign Off**	Chief Nurse		
Governance Route	Patient experience performance, risks and improvement actions are reported monthly to the Safety and Quality Assurance Group (SQAG). Exceptions, sustained non-compliance and material deterioration are escalated to the Quality and People Committee.					
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
		X				
Executive Summary	Patient experience services experienced significant workforce and operational pressures during 2025/26, with staffing falling to 3.3 WTE against an establishment of 7.87 WTE. This contributed to delays in reviewing and acknowledging contacts, incomplete Friends and Family Test submissions and reduced capacity to evidence organisational learning. Recovery actions included recruitment to full establishment, strengthened triage and mailbox oversight, simplified complaint administration and resolution of the backlog by year-end. Formal complaints increased by 58.0% to 324, while the principal themes remained clinical care, diagnosis, treatment and discharge, and access, appointments, waiting times and referrals. Limited assurance is recommended because controls were restored and improvement was evident at year-end, but compliance with core requirements could not be consistently evidenced throughout the reporting period. Priorities for 2026/27 are to sustain statutory compliance, strengthen organisational learning, improve early resolution, restore accessible FFT arrangements and provide regular assurance to SQAG and QPC.					
Recommendation	The Committee is asked to: 1. Note the patient experience activity and performance reported for 2025/26; 2. Endorse the overarching limited assurance rating 3. Seek confirmation that the 2026/27 improvement priorities will be monitored through SQAG, with exceptions and deterioration escalated to QPC.					
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	Patient and service-user feedback provides the Trust with evidence of how people experience access, treatment, communication, discharge and coordination of care. This supports the identification of recurring issues, areas of good practice and opportunities for improvement. Effective complaints, PALS and patient experience arrangements support regulatory compliance, organisational learning and public confidence. They also provide evidence that the Trust listens to feedback and acts on concerns to improve care.				
Board Assurance					
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**		
BAF-QS-C6	Quality, Safety, Clinical Outcomes and Patient Experience	12	This report contributes to mitigation of BAF-QS-C6 by providing oversight of complaints, PALS, FFT and other patient feedback. Identification of themes, monitoring of complaint standards and oversight of improvement actions support patient safety, service quality and organisational learning. Weaknesses in the timeliness, completeness or quality of patient experience processes may reduce the Trust's ability to identify emerging concerns and demonstrate that feedback is acted upon.		
BAF-PF & BAF-LG	Foundation (Performance and Leadership /Governance)	16 & 8	The report provides assurance regarding compliance with statutory complaints requirements and the governance arrangements for patient feedback. Effective oversight supports the Trust's ability to demonstrate that complaints are received, investigated and acted upon. Failure to deliver and evidence these arrangements could lead to regulatory concern, reduced public confidence and reputational damage.		
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
		X	X		X
Compliance / Regulatory Requirements	Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 16: Receiving and acting on complaints, NHS Constitution for England, Parliamentary and Health Service Ombudsman NHS Complaint Standards, Local Government and Social Care Ombudsman, NHS Standards Contract.				

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>Ethical or EDI implications?</td><td colspan="4">Patient feedback identified issues relating to reasonable adjustments, learning disabilities, autism and ADHD pathways, interpreter provision, non-digital access and support for carers and vulnerable patients. Accessible feedback routes are required to ensure that patients are not disadvantaged because of disability, language, communication requirements, digital exclusion or other individual needs.
The Patient Experience Service should continue to offer different routes through which feedback can be provided and ensure that reasonable adjustments are identified and recorded.</td></tr>
<tr><td rowspan="2">Assurance rating</td><td>Significant</td><td>Moderate</td><td>Limited</td><td>Inadequate</td></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
<tr><td>Assurance rationale</td><td colspan="4">Limited assurance is recommended. Controls and capacity improved by year-end, including restoration of the team to full establishment, strengthened triage and mailbox oversight, and resolution of the backlog. However, the Trust could not consistently evidence compliance with the three-working-day complaint acknowledgement requirement, submitted incomplete FFT datasets and had limited capacity to demonstrate organisational learning across the full reporting period. Sustained compliance and delivery of the 2026/27 priorities therefore require continued oversight through SQAG and escalation of exceptions to QPC.</td></tr>
<tr><td>Appendices</td><td colspan="4"></td></tr>
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1. Introduction and background

This report provides an annual review of patient experience activity across Torbay and South Devon NHS Foundation Trust for the period 1 April 2025 to 31 March 2026. It includes Complaints, Patient Advice and Liaison Service activity, MP Enquiries, Parliamentary and Health Service Ombudsman cases and Friends and Family Test.

It also provides an overview of the operational challenges experienced during the year, the actions taken to improve the service and the principal themes identified from patient and service-user feedback.

The Patient Experience Team experienced significant workforce and operational challenges during the first half of 2025/26 with only 3.3 WTE staff against an establishment of 7.87 WTE. Whilst there was some temporary support whilst recruitment processes took place, the reduction affected the ability to review, record and progress contacts in a timely manner.

A backlog subsequently developed within the central feedback mailbox which included answerphone messages. This meant that for part of the year, the Trust

could not accurately evidence performance against the statutory requirement to acknowledge complaints within three working days. This was reported through the Trust's governance arrangements, and a service recovery programme was implemented.

The position improved during the final quarter of 2025/26. The team had returned to full establishment, triage arrangements were introduced, complaint administration was simplified and the backlog resolved. However, delivery of all required standards could not be consistently evidenced throughout the full reporting period.

2. Purpose of report

This report provides the Committee with an annual position in relation to:

- Complaints and compliance with statutory complaint requirements
- PALS, advice and signposting
- MP enquiries
- Compliments
- Ombudsman activity
- Friends and Family Test (FFT)
- Themes identified from feedback and learning
- Workforce, process and system challenges
- Improvement priorities for 2026/27

The report provides assurance regarding the arrangements through which the Trust receives, reviews, responds to and learns from feedback. It also identifies where controls did not operate consistently and where further improvement is required.

3. Overview of 2025/26

The table below contains a breakdown by number and percentage for each contact type.

Feedback Type	**Number**	**% of Total Feedback**
Concern	1,577	**44.7%**
PALS (Comments/Suggestion/Information/Signposting/Advice/Support)	1,304	**37.0%**
Complaint	324	**9.2%**
Compliment	291	**8.3%**
MP Feedback or Enquiry	31	**0.9%**
Grand Total	**3,527**	**100.0%**

<u>Complaints and Concerns</u>
Formal complaints represented 9.2% of all feedback received during 2025/26, while concerns accounted for 44.7%. The higher volume of concerns demonstrates substantial use of informal feedback routes, but the data does not show how many

concerns were resolved before escalation or subsequently became formal complaints.

A comparison table to 2024/25 has been included within Appendix 1.

The national and regional complaint network organisations are all reporting a significant increase in the number of complaints year on year. This aligns with the Lord Darzi report published in September 2024[1] which highlighted that patient satisfaction with services has declined across the country which has seen a national wide increase in complaints.

Year	Complaints	Numerical Change	% Change
2023/24	140	-	-
2024/25	205	+65	**+46.4%**
2025/26	324	+119	**+58.0%**
2023/24 to 2025/26	140 → 324	+184	**+131.4%**

Although overall feedback volumes increased by 1.9% during 2025/26, the profile of feedback changed: formal complaints increased by 58.0%, concerns reduced by 7.9% and PALS contacts increased by 11.5%. This pattern may indicate that a greater proportion of dissatisfaction entered the formal complaints process during the period of reduced staffing and delayed contact handling; however, the available data does not establish causation. Continued monitoring is required to determine whether the shift is sustained following service recovery.

Analysis of patient feedback indicates that most complaints and concerns continue to relate to two principal themes:

- Clinical care, diagnosis, treatment and discharge
- Access, appointments, waiting times and referrals.

These themes accounted for 1,454 contacts during 2025/26, representing 41.2% of all feedback received and 76.5% of all complaints and concerns. The sustained prominence of these themes demonstrates the continued impact of clinical pathway, operational performance and care coordination issues on patient experience and provides important intelligence in relation to the Trust's principal quality, safety and operational risks.

Theme	Number	% of Total Feedback (3,527)	% of Complaints & Concerns (1,901)
Clinical care, diagnosis, treatment and discharge	964	**27.3%**	**50.7%**

[1] Department of Health and Social Care. (2024). Independent investigation of the National Health Service in England.

Theme	Number	% of Total Feedback (3,527)	% of Complaints & Concerns (1,901)
Access, appointments, waiting times and referrals	490	**13.9%**	**25.8%**
Communication, administration and records	134	**3.8%**	**7.0%**
Staff attitude and behaviour	90	**2.6%**	**4.7%**
Parking, transport and facilities	33	**0.9%**	**1.7%**

A comparison table including 2024/25 data is provided in Appendix 2.

Patient Advice and Liaison Service

PALS activity increased by 135 contacts (11.5%) between 2024/25 and 2025/26.

Analysis of PALS themes indicates no change in themes in comparison to 2024/25. The key themes are:

- Appointment updates and booking issues
- Referrals and follow-up arrangements
- Delays in receiving results
- Access to treatment and services
- Service navigation and advice
- Records and information requests
- Transport and practical support queries
- Signposting to alternative sources of support

Compliments

Although recorded compliments reduced by 40 contacts (12.1%) in 2025/26, the nature of positive feedback remained remarkably consistent across both years.

Patients and families continued to recognise:

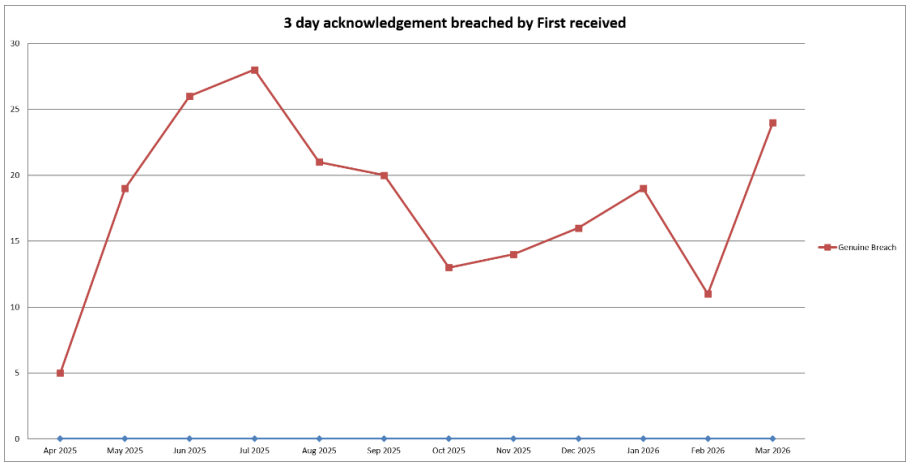
- Compassionate care
- Professionalism
- Kindness
- Reassurance
- Good communication
- Personalised support.

4. Complaints statutory requirements

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 states that all responsible bodies (such as NHS Trusts, GP practices, and local authorities) must:

- Acknowledge a formal complaint no later than three working days after the day it is received; and
- Send a written response as soon as reasonably practicable after the investigation, within this 6-month period unless a longer period has been agreed upon with the complainant

Performance against the statutory three-working-day complaint acknowledgement requirement was affected by the backlog in the feedback mailbox. The Trust did not consistently meet or evidence compliance during 2025/26, and acknowledgements were issued on average within 5 to 10 working days during the affected period. Similar pressures have been reported through regional and national complaint networks, but this does not reduce the Trust's responsibility to meet the statutory requirement.



There were 5 six-month complaint breaches reported for 2025/26. This is a 50% reduction from 2024/25.

The Secretary of State has provided a direction to NHS England to establish and operate a system for the collection and publication of data relating to written complaints received in secondary care settings. This is known as the KO41 submission.

Data is collected on an ongoing basis at provider level and is submitted centrally on an annual basis on spreadsheets through the Strategic Data Collection Service (SDCS).

The Trust completed this required submission.

Parliamentary and Health Service Ombudsman

During 2025/26, the Trust continued to cooperate fully with the Parliamentary and Health Service Ombudsman (PHSO) although there were initially delays encountered during the team's low staffing period. Nationally, the Ombudsman has reported significant growth in complaint demand, creating additional pressures on its investigation processes. Consequently, some cases may remain open for extended periods before an outcome is issued. The Trust will continue to monitor all active cases, respond within required timescales and implement learning arising from Ombudsman decisions.

There were 16 cases referred to the PHSO for review during 2025/26. Of these cases, 8 have been declined by the PHSO for investigation, 7 remain under review, and one was partially upheld.

The PHSO found that mouth care reviews, and pain scores were not consistently recorded in paper health records. An action plan was agreed, but the move to EPIC partially superseded the original actions. Assurance remains incomplete because the Trust does not yet have sufficient EPIC audit capability to demonstrate consistent recording and sustained improvement. This gap should remain under formal oversight until audit evidence confirms that the required controls are operating effectively.

5. Friends and Family Test

The Trust submitted incomplete mandatory FFT datasets during 2025/26. This limits assurance over the completeness and comparability of patient experience information and reduces the Trust's ability to identify service-level trends. Until a replacement system is implemented, an interim control is required to monitor submission completeness, outstanding returns and exceptions each month.

FFT reporting during 2025/26 was impacted by a historic processing backlog due to staffing concerns which delayed the processing of paper returns. In addition, there were system access issues. Whilst system access was restored, it is not fit for purpose and does not meet Accessible Information Standards or web accessibility guidance meaning patients struggle to complete FFT forms electronically.

The historic paper backlog has been transcribed manually but this has reduced the ability to identify trends and compare patient experience across services. Future priorities include the procurement of an alternative system and the potential to join existing One Devon Procurement processes.

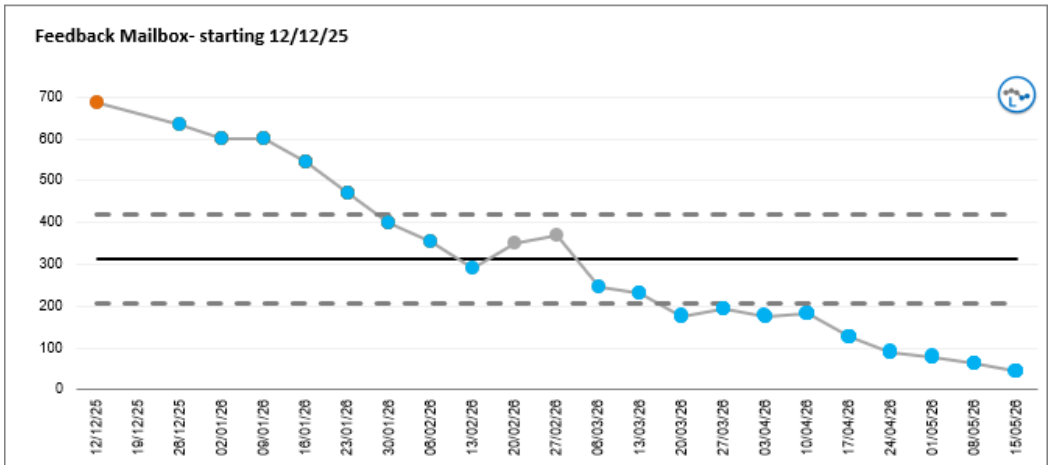
6. Improvements made during 2025/26

Over the last 12 months, the Feedback, Complaints and PALS service has undergone significant operational, workforce and process changes in response to capacity pressures, increased complaint volumes and the need to strengthen assurance arrangements.

Recruitment was undertaken during the second half of the year and the team returned to full establishment by January 2026, enabling a recovery programme to commence.

A formal recovery programme was implemented to address the backlog in the central feedback mailbox, supported by weekly oversight of activity. A triage process prioritised urgent cases and separated PALS contacts from formal complaints. A revised complaint proforma improved the quality and conciseness of information submitted to the service. Changes to Datix also enabled cases to be logged more promptly and supported more efficient case tracking.

Significant progress was made in reducing outstanding correspondence during the final quarter of 2025/26.



The team have also started the implementation of the Early Resolution process in line with PHSO best practice. The aim is to reduce formal and lengthy complaint investigations and responses where appropriate in favour of staff calling the complainant to resolve informally. A template is available to capture key information for the complainant to have a written record when requested.

7. Priorities for 2026/27

Progress against the 2026/27 priorities will be monitored through a defined delivery plan covering the action, accountable lead, target date, success measure, status and evidence of impact. SQAG will review progress monthly, with overdue actions,

sustained non-compliance or deterioration in patient experience measures escalated to QPC.

Organisational learning
During 2026/27, completed complaints will be coded consistently to enable service-level and thematic analysis. Recurring themes, associated actions and evidence of impact will be reported through the Feedback Group and SQAG, with material risks and overdue actions escalated to QPC.

Improve early resolution and reduce escalation to formal complaints
Awareness and training materials will be provided to support staff to use the early resolution process consistently, including workplace turbo-teaching sessions in clinical areas and updated intranet guidance. Delivery will be monitored through uptake of training, the proportion of suitable cases resolved early and the rate of escalation to formal complaints.

Online Complaint and PALS Forms
Online complaint and PALS forms have been developed and are planned for launch by 31 December 2026. The forms are intended to reduce avoidable email contact, improve the completeness of information received and capture each complainant's communication preferences. Telephone and paper routes will remain available to support accessibility and non-digital access.

Restore and improve FFT arrangements
A sustainable and accessible FFT collection and reporting system will be procured and implemented. The delivery plan will include an accountable lead, procurement and implementation milestones, interim controls for complete monthly submissions, compliance with accessibility requirements and a date by which service-level trend reporting will be restored.

A pilot is currently underway with the AAA Screening Team who were awarded a free contract from Care Opinion to trial responding to their feedback directly as a service. Since the pilot started in August 2026 they have received 17 patient feedback stories. Your stories | Care Opinion.

Feedback Group
During 2026/27, the Feedback Group will be re-established with a renewed focus on organisational learning and improvement. The Group will provide oversight of patient experience themes, support the sharing of learning across services, monitor improvement actions and strengthen the use of patient feedback.

Translation and Interpretation Services
Work is progressing across the Devon system to procure new contracts for interpretation and translation services, including telephone, video and face-to-face interpretation, British Sign Language (BSL) services, written translation and accessible formats. The procurement aims to establish a more consistent and sustainable service model, strengthen contract management arrangements and

support greater use of telephone and video interpretation where clinically appropriate. An Equality and Quality Impact Assessment and supporting governance arrangements have been developed in parallel to ensure patient safety, accessibility, equality and safeguarding considerations remain central to the procurement process.

The scheme is also expected to contribute to financial sustainability through improved commercial arrangements and reduced reliance on higher-cost face-to-face provision, while maintaining equitable access to communication support for patients.

Appendix 1

Feedback Type	2024/25	% of Total 2024/25	2025/26	% of Total 2025/26	Numerical Change	% Change
Concern	1,712	49.5%	1,577	44.7%	-135	-7.9%
PALS (Comments/Suggestion/Information/Signposting/Advice/Support)	1,169	33.8%	1,304	37.0%	+135	+11.5%
Complaint	205	5.9%	324	9.2%	+119	+58.0%
Compliment	331	9.6%	291	8.3%	-40	-12.1%
MP Feedback or Enquiry	44	1.3%	31	0.9%	-13	-29.5%
Grand Total	**3,461**	**100%**	**3,527**	**100%**	**+66**	**+1.9%**

Appendix 2

Theme	2024/25 (% Total Feedback)	2025/26 (% Total Feedback)	Change
Clinical care, diagnosis, treatment and discharge	27.6%	27.3%	Stable
Access, appointments, waiting times and referrals	14.0%	13.9%	Stable
Communication, administration and records	7.1%	3.8%	Reduction
Staff attitude and behaviour	3.3%	2.6%	Reduction
Parking, transport and facilities	1.0%	0.9%	Stable

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Presented to:	**Quality and People Committee**			
Title of Report	**Safeguarding Children Annual Report 2025/26**			
Date of Meeting	22 September 2026	**Author**	Phillipa Hiles, Named Nurse Safeguarding Children Natalie Herring, Deputy Chief Nurse	
Executive Lead	Nicola McMinn, Chief Nurse	**Executive Sign Off**	Approved 14 September 2026	
Governance Route	Safeguarding Children Operational Group (SCOG) -> Integrated Safeguarding and Inclusion Group (ISIG) -> Quality and People Committee			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		X		
Executive Summary	This statutory annual report provides the Quality and People Committee with assurance on how the Trust discharged its safeguarding children responsibilities between July 2025 and June 2026. Core safeguarding governance and controls remain in place, supported by statutory oversight, training, audit, review activity and multiagency working. Demand and complexity have increased, creating pressure on workforce capacity within the Torbay 0–19 Plus and Safeguarding Children teams and contributing to delays in some activity. Further areas requiring oversight are reduced accessibility of safeguarding data following implementation of EPIC; Risk 99 concerning the visibility of contacts for children looked after; and uncertainty arising from the Families First Partnership programme and changes to ICB safeguarding provision. Mitigating actions are monitored through the Safeguarding Children Operational Group, reported to the Integrated Safeguarding and Inclusion Group and escalated to executive leads where required. These include targeted workforce and training support, monthly review of demand and delivery, audit and quality-assurance activity, implementation of learning from reviews, policy updates, EPIC action tracking and active representation in local and system workstreams. This report is a source of assurance for the Board Assurance Framework principal risk that children and young people may experience avoidable harm if the Trust's safeguarding arrangements, workforce capacity, information systems or partnership interfaces are not effective. It provides evidence on the design and operation of key controls, including statutory governance, training, supervision, audit, learning from reviews, multiagency working and escalation through SCOG and ISIG. Risk 99, currently scored 8, is a specific gap in the control environment because the visibility of contacts for children looked after within EPIC may result in inappropriate disclosure of sensitive information, with potential consequences for a child's safety and placement stability. Workforce pressure, rising demand and national and ICB changes are additional emerging threats to the continued effectiveness of controls and are being assessed for inclusion or escalation within the BAF process. Overall, **moderate assurance** is proposed: the controls are operating and provide evidence that the principal risk is being managed, but gaps remain and further evidence is required that mitigating actions are reducing risk and can be sustained. Any deterioration in delivery, control effectiveness or residual risk will be escalated through ISIG to QPC and reflected in the BAF assurance assessment.			
Recommendation	The Quality and People Committee is asked to: **1.** Note the statutory assurance provided by the Safeguarding Children Annual Report 2025/26; **2.** Approve the proposed **moderate assurance** rating, recognising that core safeguarding controls are operating but that further evidence of sustained improvement is required; **3.** Note Risk 99 and the emerging workforce, demand and system-change risks, and their relevance to the Board Assurance Framework; and **4.** Require continued monitoring through SCOG and ISIG, with an exception report returned to QPC if delivery deteriorates, controls are assessed as ineffective, mitigating actions are not completed to plan, or the residual risk increases.			

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**

1

Torbay and South Devon NHS Foundation Trust

Presented to:	**Quality and People Committee**				
How this paper supports delivery of the Strategy	The paper supports children and families to live well and safely by maintaining effective safeguarding controls; develops a caring and skilled workforce through training and supervision; enables joined-up care through multiagency governance and information-sharing; and strengthens the organisational foundation through clear accountability, risk management and continuous improvement.				
Board Assurance					
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**		
Risk 99	Visibility of contacts for children looked after within EPIC, with a risk of communication being sent to an incorrect individual.	**8**	Provides QPC with assurance on the design and operation of controls for Risk 99, including ownership through SCOG, EPIC-related action tracking and escalation through ISIG. This evidence informs the BAF assessment of whether safeguarding controls are effective in preventing avoidable harm and inappropriate disclosure of sensitive information.		
Emerging risks	Workforce capacity, increased safeguarding demand, Families First Partnership implementation and changes to ICB safeguarding provision.	Under review	Identifies potential gaps in the BAF control environment arising from workforce capacity, sustained demand, Families First Partnership implementation and changes to ICB safeguarding provision. These risks are being assessed through SCOG and ISIG, with executive oversight and escalation where the impact, likelihood or adequacy of controls changes.		
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	X			**X**	**X**
Compliance / Regulatory Requirements	Working Together to Safeguard Children (2026); Children Act 1989 and 2004, including Section 11; statutory Child Death Review requirements; and relevant safeguarding partnership arrangements.				
Ethical or EDI implications?	Safeguarding arrangements support equitable access to protection and support for children and families. The report notes the need for appropriate and equitable health representation in future partnership arrangements.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
		X			
Assurance rationale	**Moderate assurance** is proposed. There is evidence that statutory safeguarding governance, training, audit, review and partnership controls are designed and operating. However, assurance is moderated by sustained workload pressure, gaps in timely delivery, the evolving impact of EPIC and uncertainty about national and system changes. These matters are subject to defined mitigation, monthly operational oversight and escalation routes, but further evidence of sustained improvement is required before significant assurance can be recommended.				
Appendices	Appendix 1 - Safeguarding Children: Trust risks Appendix 2 - Local Child Safeguarding Practice Reviews and Trust actions Appendix 3 - Safeguarding Children Operational Group dashboard (separate spreadsheet) *Appendices in the Items for Information Pack*				

Torbay and South Devon NHS Foundation Trust

Detailed Annual Report

Introduction and purpose

This statutory annual report sets out progress against the Trust's safeguarding children priorities for July 2025–June 2026. It is presented to QPC to provide assurance that the Trust is discharging its responsibilities under Working Together to Safeguard Children (2026) and section 11 of the Children Act 2004, and to highlight the risks, controls and improvement actions requiring Committee oversight.

Assurance is drawn from performance data, audits, safeguarding reviews, training compliance, supervision, partnership activity and operational oversight by the Safeguarding Children Operational Group (SCOG), chaired by the Associate Director of Nursing and Professional Practice. SCOG reports through the Integrated Safeguarding and Inclusion Group, with executive escalation where required.

The Trust continues to engage actively with both Devon and Torbay Safeguarding Children Partnerships, ensuring executive-level health representation and input into operational sub-groups covering quality assurance, neglect, child exploitation, safeguarding practice review, and related priorities.

1. Key Risks

Key Safeguarding Children Risks – Summary

The Trust continues to monitor a number of key safeguarding risks through the Safeguarding Children Operational Group (SCOG). Current areas of focus include:

1. Timeliness of Initial Health Assessments for children entering foster care, with ongoing work to meet national targets.
2. Capacity constraints within the Torbay 0 to 19 Plus Public Health Nursing Team and the Safeguarding Children Team, which may impact the Trust's operational service and quality assurance responsibilities.
3. Information accessibility for data reporting following the launch of the EPIC patient electronic record, affecting the ability to maintain professional oversight and support safeguarding practice.
4. Implementation of the Families First Partnership programme, with potential operational impacts pending national guidance.

These risks are actively monitored through SCOG, with named actions, operational mitigation and escalation where required. Risk 99 and the emerging workforce, demand and system risks inform the Trust's BAF assessment of the effectiveness of safeguarding controls. Full risk descriptions and scores are provided in Appendix 1.

2. Update on Child Safeguarding Practice Reviews (CSPR)

The Torbay and Devon Safeguarding Children Partnerships retain accountability for undertaking and publishing Child Safeguarding Practice Reviews (CSPRs), rapid reviews, and after-action reviews. During the reporting period, several reviews have been completed, covering issues such as child deaths, neglect, child mental health, and child criminal exploitation.

Where actions have been identified for the Trust, these have focused on strengthening professional curiosity, promotion of safe sleep guidance, embedding routine enquiry into maternity services, and updating patient record systems to show missed appointment history. All actions are being monitored through the Safeguarding Children Operational Group (SCOG), with progress overseen by the Deputy Chief Nurse.

The Trust continues to contribute actively to the multiagency CSPR subgroups through the Named Nurse for Safeguarding Children, ensuring that learning is identified, disseminated to service leads, and embedded into practice. This provides assurance to the Board that safeguarding learning is effectively acted upon and that governance processes are in place to evidence compliance**.**

Appendix 2 provides further detail on individual reviews, associated action plans, and progress updates for information.

3. Update on Child Death review statutory process

3.1 Child death review activity, July 2025–June 2026

Reported deaths, 1 July 2025–30 June 2026		Under 1 year	Age 1–17 years
Unexpected	**3**	1	2
Expected	**6**	6	0

Early Response Meetings	Child Death Review Meetings
0 held 2 attended	**5 held**

3.2 Governance process.

The Child Death Review process is a statutory requirement under Working Together to Safeguard Children (2026). Meetings convened include Early Response meetings (ERM), Child Death Review meetings (CDRM) and Perinatal Mortality Review Tool meetings (PMRT).

The Trust has appropriate governance in place, with a designated Child Death Review Coordinator and Named Doctor, ensuring compliance with statutory and professional standards. All reviews are anonymised and reported through the Child Death Overview Panel (CDOP), with serious incidents escalated to the One Devon ICB and local Safeguarding Children Partnerships.

Learning is shared internally via the Safeguarding Children Operational Group (SCOG), Child Health governance meetings and Mortality Surveillance group. Trust actions are included in the SCOG workplan and monitored at the monthly meetings.

Established governance arrangements ensure that the child death review process provides contemporaneous oversight and assurance to the Trust Board.

3.4 **National Child Mortality Database (NCMD) Reports and Audits**

The NCMD provides thematic learning from child death reviews to provider agencies. During the reporting period, the Trust completed audits on most common modifiable factors, falls from windows / balconies, children with life limiting conditions and understanding consanguinity-related child deaths.

All audits were submitted within required timescales, and identified actions have been completed or are actively monitored through the Safeguarding Children Operational Group (SCOG) and relevant governance forums, providing assurance to the Board that learning is embedded into practice.

4. Key workload challenges:

Safeguarding Children – Operational Overview

Performance data for July 2025–June 2026 demonstrates that safeguarding arrangements continue to meet statutory requirements, with consistent oversight of multiagency Child Protection activity, including neglect and emotional abuse. Activity levels continue to increase, whilst also reflecting increasing complexity for children, young people, and families, including rising demand for child protection medicals, court reports, attendance to strategy meetings and safeguarding supervision. There are delays identified in provision of the service, which are managed in accordance with Trust policies and communicated to multiagency partners where necessary.

While operational pressures on the Torbay 0 to 19 Plus service and Safeguarding Children Team have been noted, these are actively managed through governance structures, including the Safeguarding Children Operational Group (SCOG), and monitored against statutory obligations. Workforce capacity has been recognised as

a challenge, with mitigating actions in place to ensure the delivery of safe and effective safeguarding practice.

5. Key Improvements:

The Trust has made significant progress in strengthening safeguarding children practice and governance. All Trust safeguarding policies are being updated to align with Working Together to Safeguard Children (2026), following recommendations from the Section 11 self-assessment, with a regular agenda item at SCOG to monitor policy update requirements and progress.

Audits and quality assurance activities have been completed or are underway across key areas, including child protection medicals, health response to Police Information sharing (PPN), MASH dip samples and professional curiosity practice across services. The Joint Targeted Area Inspection (November 2023) triggered the the launch of professional curiosity resources to support supervision, training, and practice improvements across Trust services and this has been evidenced in recent audited completed in conjunction with the Torbay Local Authority. Future Trust audits will be completed with inclusion of clear focus of evidence of professional curiosity and impact on the child.

Safeguarding supervision is embedded for Level 3 trained staff, with service improvements enhancing accessibility, flexibility, and support for frontline teams. The Trust continues to provide 100% health service provision within the Torbay MASH, ensuring robust multiagency safeguarding oversight and timely intervention. These developments demonstrate the Trust's commitment to continuous improvement and provide assurance to the Board that safeguarding arrangements are effective and responsive to emerging needs, including the implementation of the changes indicated in the Family First Partnership programme.

6. Safeguarding Children's Training compliance

Safeguarding children training compliance across the Trust has shown sustained improvement over the reporting period, despite challenges such as staffing pressures and seasonal workload. Level 1 and 2 statutory training remain consistently above target, while Level 3 compliance improved from to over 80% between August and December 2025, this was not sustained due to the pressures of staff training for the EPIC patient electronic record. Measures are currently in place to support improvements across services, where required.

The following staff groups with higher risk exposure, are monitored closely through the Safeguarding Children Operational Group (SCOG).

1. Torbay 0–19 Public Health Nurses,
2. Emergency Department,
3. Louisa Cary Ward,
4. Special Care Baby Unit,

5. Maternity services
6. Paediatricians

Where compliance gaps exist, targeted support is provided, including additional "turbo-training," supervision, and facilitated access to induction training for new staff. The Safeguarding Children Team maintains 100% compliance and leads induction and ongoing training, providing assurance that staff are supported to meet statutory safeguarding obligations.

7. National Changes

Working Together to Safeguard Children (2026) remains the core statutory guidance for interagency safeguarding practice. Implementation is closely linked to the Families First Partnership Programme, which sets out expected practice changes to improve support for children and families. These national changes are expected to be in place by March 2027. Torbay and Devon Local Authorities are implementing these measures slightly differently and negotiation is in progress, with oversight of ICB Designated Professionals, to support appropriate and equitable health representation in the updated service offer.

The Trust is actively engaged in the Torbay workstreams, with representation at strategic and operational levels, though the impact on Trust services remains unclear.

Future system changes, including ICB strategic commissioning and efficiency requirements, may affect safeguarding processes, and the Trust continues to engage nationally and regionally to ensure statutory responsibilities and service provision are maintained.

8. Inspection outcomes – including JTAI, CQC and Section 11

Torbay Local Authority will be subject to Joint Targeted Area Inspection (JTAI) which will impact Torbay and South Devon Foundation Trust as one of the partner agencies, including the organisation responsible for providing health support in MASH (Multi Agency Safeguarding Hub). The previous inspection was completed in November 2023; all Trust actions have been completed.

Key themes addressed included

1. Professional Curiosity,
2. Quality Assurance
3. Data Reporting.

Outstanding actions from the Section 11 self-assessment are completed or progressing, including updates to safeguarding policies, integration into the appraisal

system, and alignment with EPIC electronic records, all monitored via SCOG and fed into ISIG.

9. Overall assurance and recommendations

Section		Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1.	Key Risks	Satisfactory	On track
2.	Update on CSPR	Satisfactory	On track. Work in progress on current identified actions – no new activity for TSCP.
3.	Update on Child Death review	Satisfactory	On track
4.	Key workload challenges	Limited	Emerging risk - Sustained increased workload challenges – deadlines not met but work continues to be progressed. Imminent risk of FFP service changes and recently reviewed ICB service provision.
5.	Key Improvements	Satisfactory	On Track. Positive progress on Peninsula partnership actions – Data workstream for JTAI actions completed and now in practice.
6.	Safeguarding Children Training Compliance	Satisfactory	On Track. Progress in place and supported via Service Leads.
7.	National changes	Limited	Emerging risk. Planning in progress for FFP service changes – impact on Trust services remains unclear – oversight of Exec and ICB.
8.	Inspection outcomes	Satisfactory	On track. Work complete and assurance process in progress.

Overall conclusion: The report supports a moderate assurance rating. The Committee can take assurance that statutory safeguarding governance and core controls are operating, while recognising that sustained demand, workforce capacity, Risk 99 and national system changes require continued monitoring. The Committee is asked to note the report, agree the assurance rating and endorse escalation to QPC if the adequacy of controls or delivery position deteriorates.

Appendices - Safeguarding Children Annual Report 2025/26

Appendix 1 Safeguarding Children – Trust risks

Risk 99 score: 8
Cause: Children who are looked after whose details were migrated over from the 0-19 Team (Torbay) have extended contacts visible on their record. Children not under 0-19 Team and all children new to cares since EPIC migration have these contacts (usually family members such as birth parents or siblings) inactivated but those migrated, as above, still have these contacts visible. EPIC should only have a primary contact as their foster carer; other contacts should be inactivated during their period of care to prevent those accessing the records inadvertently contacting the wrong carer.
Event: This could lead to EPIC generating communications or staff contacting an incorrect individual, resulting in the inappropriate sharing of sensitive information (e.g. appointment details).
Impact: Risk to the personal safety and stability of the child and foster placement Breach of confidentiality and potential reportable data breach

Under review at SCOG as emerging risks

Cause: Impact of implementation on Trust operational services of the Families First Partnership programme in accordance with the Department of Education Childrens social care reforms. The programme provides updated delivery expectations for safeguarding partners in England following the national review of the deaths of Star Hobson and Arthur Labinjo-Hughes.
Event: Reconfiguration of service provision for safeguarding children may result in altered requirements from Health staff, with potential high likelihood on impact on Torbay 0 to 19 Plus service and Torbay Safeguarding Children Team (TSDFT)
Impact: Impact currently unknown – awaiting further detail at workstreams – operational and strategic representation for Trust at these events. (identified July 2025)

Cause: Continued increase in safeguarding assessment demand on operational services, including Health in Torbay MASH, impacting organisation responsibilities within Local Safeguarding partnerships and Section 11 responsibilities.
Event: ICB reorganisation has resulted in withdrawal of ICB representatives at Partnership duties, resulting in Partner organisation attendance / backfill
Impact: Impact currently unclear – awaiting final details of planned service provision of Designated Safeguarding professionals and clarity of expectations for partner agencies, including TSDFT.

Appendix 2 Local Child Safeguarding Practice Reviews and Trust actions

C110/111/112 – Child Safeguarding Practice review (Child death)
C105/106/107 – After Action review (Neglect)
C104 – After Action review (Children mental health)
C101 – Rapid review
C100 – Rapid review
C95 – After Action review (Child criminal exploitation)

Trust actions for reviews:

TSCP

C110/111/112 – Safe sleep advice, CPR training for parents, professional curiosity embedding into practice, staff awareness of potential additional parenting needs of care experienced parents. **Trust actions – completed**.
C105/106/107 – learning re professional curiosity, flagging of patient record systems, use of the Graded Care profile tool to evidence neglect and using the TSCP professional differences policy. **Trust actions – completed**.
C104 – CFHD report re reducing waiting times for therapeutic support, CFHD to provide partners with information of interventions available to support partnership understanding of resources. **Trust actions – completed**.
C94 – improved professional curiosity when undertaking visits, to be supported through training and supervision. Audit undertaken to evidence impact in current practice. **Trust actions – completed**.
C95 – awaiting report / to be drafted.

DSCP has undertaken 3 rapid reviews: 1 had identified input from TSDFT services in the provision of care for the child / family.

Learning briefings released by DSCP when they have been published are shared with Trust staff via the staff bulletin and the Safeguarding Supervisor network to operational teams.
No current identified actions for the Trust identified by DSCP during the timescale for this report.

PSCP has undertaken 5 rapid reviews; 1 had identified input from TSDFT services in the provision of care for the child / family.

No current identified actions for the Trust identified by PSCP during the timescale for this report.

uthority Child Protection Data

July 2025 - June 2026	Quarter 2			Quarter 3			Quarter 4			Quarter 1		
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
TORBAY												
Number of children on a CP plan	146	154	145	142	137	145	150	160	160	145	154	164
of which Sexual Abuse	2	2	2	6	6	6	6	6	7	7	9	8
of which Emotional Abuse	23	28	25	24	26	30	33	33	36	31	32	34
of which Physical Abuse	2	2	2	1	1	1	1	1	3	2	2	2
of which Neglect	105	107	99	99	91	100	102	112	106	99	101	108
of which are multiple categories	14	15	14	12	13	8	7	8	8	6	10	12
of which are unborn	7	6	4	4	6	5	4	4	4	4	5	5
of which 0-1	18	21	21	21	18	27	26	29	25	21	19	21
of which 2-4	22	28	25	23	21	21	24	24	24	19	20	18
of which 5-18	99	99	95	94	92	92	96	103	107	101	110	120
Total on CP plan for longer than 9 months	35	31	38	38	34	38	38	41	46	47	53	57

July 2025 - June 2026	Quarter 2			Quarter 3			Quarter 4			Quarter 1		
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
DEVON												
Number of children on a CP plan	448	453	439	399	371	354	399	399	401	380	383	396
of which Sexual Abuse	19	16	15	14	12	12	13	13	14	14	12	11
of which Emotional Abuse	214	226	202	181	153	133	164	164	169	150	151	159
of which Physical Abuse	15	18	18	15	15	14	14	14	16	25	25	25
of which Neglect	200	193	204	189	191	195	208	208	202	191	195	201
of which 0-1	53	51	58	55	52	58	63	63	62	57	58	60
of which 2-4	65	70	68	61	60	61	75	75	77	68	70	76
of which 5-18	316	319	300	270	245	227	247	247	253	249	247	253
Total on CP plan for longer than 9 months	124	141	159	168	142	157	147	147	151	110	108	107

Safeguarding Children Dashboard Data

July 25 - June 26	Quarter 2			Quarter 3			Quarter 4			Quarter 1		
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
TSDFT Maternity Services												
Total Torbay Unborn on CP plan	10	7	6	4	6	8	10	5	5	3	5	5
Total South Devon Unborn on CP plan	2	2	1	1	1	1	1	1	1	1	1	2
Removals at birth	0	0	2	2	0	0	0	0	0	1	0	0
Torbay UB Tracker	16/2	16/2	20/2	15/1	20/2	09/1	18/2	15/2	13/2	21/3	16/2	14/2
Devon supportive Pregnancy Pathway meeting	CSC 10+7 Devon EH 2	CSC 9+3 Devon EH 3	CSC 8+6 Devon EH 3+2	CSC 7+6 Devon EH 2	CSC 9+ Devon 8 EH 2	CSC 9+5 EH 3	CSC 6+4	CSC 6+7 Devon EH 3+2	CSC 7+4	CSC 6+7	CSC 5+6	CSC 4+8
Public Health Liaison (added Apr 22) (Previously Vulnerable babies)	5	Not held	6	2	2	4	EH 3+0	Not held	3	3	0	6
Torbay Early Help Panel	0/2	0/2	0/2	0/2	0/2	not attended	Not held	0/2	0/2	0/2	0/1	4/3
Number of Court Reports written (added Sept 24)	1	1	0	1	2	0	0/2	0	0	2	2	0
Torbay Safeguarding Children Team - MASH												
Public Protection Notice - PPN's	611	482	451	535	474	539	451	448	563	468	495	656
Health checks	92	70	64	52	65	105	94	80	72	56	99	105
MASH Enquiries	118	98	116	128	112	106	128	121	118	73	119	139
Strategy Meetings	13	18	16	14	16	14	30	17	14	16	18	22
Duty Calls	10	11	14	15	7	19	10	10	7	6	10	Item to be removed
Total Exploitation (red toolkit) special case flags	10	12	12	14	11	11	10	11	12	12	11	44
Devon Safeguarding Children Team - SPA/MASH/Duty												
MASH Health Information Gathering	193/516	136/272	196/406	211/433	204/347	219/439	196/396	181/391	173/347	113/247	124/291	162/327
Strategy Meetings	27	14	24	32	17	18	37	20	34	28	30	23
Duty Contacts	649	454	467	452	365	304	543	410	509	329	409	620
TSDFT (only) Paed Liaison service												
Paed Liaison Referrals	289	245	252	249	268	244	240	249	219	180	216	212
MARAC (ED/MIU referrals)	10	9	5	3	5	5	1	2	4	0	0	0
Torbay MASH referrals (ED /MIU)	22	22	16	18	21	11	22	14	12	14	19	33
Devon MASH referrals (ED/MIU)	21	17	13	16	19	17	22	12	10	5	11	16
OOA MASH referrals (ED/MIU)	5	3	3	1	1	1	2	1	0	0	2	2
Dental extractions DSU (5 teeth or more)	20	14	5	12	10	13	16	15	11	6	6	4
TSDFT (only) Paediatrician Safeguarding Activity												
Bruising or injury to non-mobile babies - under 1	**2**	**3**	**0**	**1**	**1**	**1**	**3**	**2**	**0**	**0**	**0**	**0**
Child Protection Medicals - Torbay, under 1	2	3	0	2	1	1	3	2	0	0	0	0
Child Protection Medicals - Torbay, under 2	1	1	0	0	1	0	1	1	0	2	0	1
Child Protection Medicals - Torbay, 2-4	2	1	0	3	0	0	4	1	5	3	2	2
Child Protection Medicals - Torbay under 5-9	0	0	0	0	1	0	3	3	3	1	0	1
Child Protection Medicals - Torbay 10-14	1	0	0	0	1	0	0	0	0	0	0	1
Child Protection Medicals - Torbay 15-17	0	0	0	0	0	0	0	0	0	0	0	0
Total Child Protection Medicals - Torbay	**6**	5	0	5	4	1	11	7	8	6	**2**	**5**
Bruising or injury to non-mobile babies - under 1	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	0	1
Child Protection Medicals - Devon, under 1	0	0	1	1	0	0	0	0	0	0	0	1
Child Protection Medicals - Devon, under 2	0	0	0	0	0	0	1	1	0	0	0	1
Child Protection Medicals - Devon, 2-4	0	0	2	1	0	0	0	0	1	0	0	2
Child Protection Medicals - Devon under 5-9	0	0	0	0	0	0	0	1	0	0	0	0
Child Protection Medicals - Devon 10-14	1	0	0	0	0	0	0	0	0	0	0	0
Child Protection Medicals - Devon 15-17	0	0	0	0	0	0	0	0	0	0	0	0
Total Child Protection Medicals - Devon	1	0	3	2	0	0	1	2	1	0	**0**	**4**
Total CP medicals Torbay & Devon combined	7	5	3	7	4	1	12	9	9	6	2	9
Strategy meetings attended by Paediatrians	9	6	6	10	9	4	9	14	12	4	2	7
Mental Health												
Total AE attendances relating to mental health	Unable to access this data			Unable to access this data						Unable to access this data		
Number of open ward stays for children MH services												
ED referrals to CAMHS service												
Number of referrals to community eating disorder service												
Child Deaths												
Child Deaths - Torbay	0	1	0	0	1	1	2	0	0	0	0	0
Child Deaths - South Devon	0	1	0	0	0	1	1	0	0	0	0	0
CSPR/Rapid Reviews												
CSPR - Torbay	0	0	0	0	0	0	0	1	1	0	0	0
After Action Review - Torbay	0	0	0	0	0	0	0	0	0	0	0	0
Rapid Reviews -Torbay	0	0	0	0	0	0	0	0	0	0	1	0
CSPR - Devon	0	0	0	0	0	0	0	0	0	0	0	0
Rapid Reviews - Devon	0	0	0	0	0	1	0	0	0	0	0	0
Rapid Review - Plymouth	0	0	0	0	0	1	0	0	0	1	0	0
Public Health Nursing (Torbay)												
Requests for Court Reports	14	5	6	1	3	3	4	5	1	11	8	3
Attendance to Court (support)	0	0	0	0	0	0	0	0	0	0	0	0
Training												
Statutory - Public Health Nursing												
Level 1 (Target = 80%)	98%	92%	90%	100%	100%	100%	100%	94%	92%	89%	100%	89%
Level 2 (Target = 80%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Level 3 (Target = 80%)	89%	90%	80%	91%	89%	89%	85%	91%	89%	88%	88%	89%
Statutory - ICO												
Level 1 (Target = 80%)	87%	88%	89%	89%	89%	89%	89%	88%	88%	87%	88%	89%
Level 2 (Target = 80%)	89%	89%	89%	89%	89%	89%	88%	88%	87%	86%	87%	86%
Level 3 (Target = 80%)	79%	81%	81%	79%	78%	82%	78%	79%	75%	72%	73%	75%

1

Presented to:	Quality and People Committee					
Title of Report	Safeguarding Adults Annual Report 2025/2026					
Date of Meeting	27th October 2026		**Author**	Deborrah Kelly, Deputy Safeguarding Adults Lead; Alison Kingdon, Health and Social Care Programme Manager for Safeguarding Adults / MCA and DoLS; Emma Goodall, Principal Social Worker, Adult Social Care, Torbay Council		
Executive Lead	Chief Nurse		**Executive Sign Off**			
Governance Route	Quality Assurance Committee; Adult Social Care assurance and partnership governance arrangements.					
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**		
		X				
Executive Summary	This report provides limited overall assurance on adult safeguarding arrangements during 2025/26. Safeguarding Adults, Mental Capacity Act practice, Prevent and domestic abuse are assessed as satisfactory; however, limited assurance remains for Deprivation of Liberty Safeguards and Community Deprivation of Liberty because of continuing backlogs, constrained specialist capacity and the risk of delayed lawful authorisation. The DoLS backlog reduced from 544 cases at 31 March 2026 to 471 cases in August 2026, but the residual statutory risk remains material. QPC is asked to review whether the controls, trajectory and planned actions are sufficient, with particular attention to DoLS, Community DoL, Level 3 safeguarding training compliance, data quality and continuity of governance through the Adult Social Care transition.					
Recommendation	The Quality and People Committee is asked to: (1) endorse the proposed overall Limited assurance rating and the individual domain ratings; (2) confirm whether the evidence and controls described provide sufficient assurance on safeguarding adults arrangements during 2025/26; (3) note the continuing statutory and operational risks associated with DoLS and Community DoL backlogs; (4) seek assurance that recovery actions have named owners, milestones, trajectories and escalation arrangements; and (5) require exception reporting during 2026/27 if performance deteriorates, milestones are missed or transition arrangements weaken control effectiveness.					
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
How this paper supports delivery of the Strategy	The report supports people to live well by providing assurance that adults with care and support needs are protected from abuse, neglect and improper treatment. It demonstrates person-centred safeguarding, partnership working, workforce development, lawful decision-making and continued improvement across health and social care.					

Board Assurance			
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
BAF-QS	Risk IDs 147 and 144	12	Provides assurance on controls and improvement activity for Deprivation of Liberty Safeguards and Community Deprivation of Liberty, including backlog oversight, risk-based triage, additional assessment capacity and governance monitoring.
BAF-QS	Safeguarding / quality and individual experience	12	Provides assurance on safeguarding practice, statutory compliance, training, partnership governance, equity of access and the management of emerging risks during organisational transition.

Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	X	X		X	X
Compliance / Regulatory Requirements	Care Act 2014; Mental Capacity Act 2005; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13; Deprivation of Liberty Safeguards; Human Rights Act 1998; Equality Act 2010; Modern Slavery Act 2015; Counter-Terrorism and Security Act 2015; Safeguarding Vulnerable Groups Act 2006; Domestic Abuse Act 2021; Data Protection Act 2018 and UK GDPR.				
Ethical or EDI implications?	Making Safeguarding Personal, lawful consent and best-interest decision-making support inclusion and protect individual rights. The report identifies incomplete ethnicity recording as an ongoing data-quality issue requiring improvement to strengthen assurance on equitable access and outcomes.				

Assurance rating	Significant	Moderate	Limited	Inadequate
			X	

Assurance rationale	Limited overall assurance is proposed because the control framework is established but is not yet operating effectively enough to reduce all material risks to an acceptable level. The DoLS backlog remained high at 471 cases in August 2026, Community DoL cases also remained awaiting progression, and delays continue to create a risk of unlawful deprivation of liberty and breach of Article 5 rights. Safeguarding Level 3 training compliance was 65.4% against an 85% target, and weaknesses remain in demographic data completeness and the consistency of assurance through organisational transition. Mitigations include risk-based triage, weekly safety huddles, additional independent assessment capacity, case validation, management oversight and formal risk reporting. These controls provide evidence of active management and an improving trajectory, but not yet sufficient evidence of sustained effectiveness to support a higher rating.
Appendices	Detailed Safeguarding Adults Annual Report (Adult Social Care) 2025/2026 follows this cover sheet.

Safeguarding Adults Annual Report 2025/2026

QPC assurance dashboard			
Domain	**Assurance**	**Evidence and trajectory**	**Residual gap**
DoLS	Limited	Backlog reduced from 544 at 31 March 2026 to 471 in August 2026.	Residual Article 5 risk and constrained specialist capacity.
Community DoL	Limited	Approximately 110 cases awaited allocation; additional funding secured for 2026/27.	Backlog, Court of Protection timescales and specialist assessment capacity.
Safeguarding Adults	Satisfactory	Activity and Section 42 conversion increased; enquiries open beyond 90 days reduced to 25 by Q2 2026/27.	Improvement must be sustained and complex cases protected from avoidable drift.
Workforce capability	Limited against trajectory	Level 3 compliance was 65.4% against the 85% target.	Recovery trajectory, named accountability and escalation thresholds require clear evidence.
Data quality	Limited	Ethnicity was not stated in 23% of concerns and 28% of enquiries in Quarter 1 2026/27.	Incomplete demographic data limits assurance on equitable access and outcomes.
Transition governance	Developing	Multiple oversight routes are in place.	Ownership, escalation and post-transition reporting must remain explicit and continuous.

Introduction and background

This report provides an overview of safeguarding activity, performance, learning and improvement across Adult Social Care and Torbay and South Devon NHS Foundation Trust during 2025/26. The reporting period was characterised by significant organisational change as preparations continued for the transition of Adult Social Care responsibilities from TSDFT to Torbay Council. Safeguarding adults remained a core priority, supported by established governance and partnership arrangements; however, material gaps remained in deprivation of liberty timeliness, workforce compliance and data quality, which are reflected in the overall Limited assurance rating.

The organisation has continued to be guided by the principles of the Care Act 2014 and Making Safeguarding Personal, ensuring that adults with care and support needs are supported to achieve outcomes that reflect their wishes, strengths, and individual circumstances. Safeguarding practice has remained focused on promoting wellbeing, preventing harm, protecting people at risk, and working collaboratively with individuals, families, carers, and partner agencies.

During 2025/26, significant progress has been made in strengthening safeguarding arrangements through quality assurance activity, workforce development, safeguarding supervision, policy development, and multi-agency collaboration. Learning from safeguarding enquiries, audits, complaints, feedback, and Safeguarding Adults Reviews has continued to drive service improvement and support the development of professional practice across the workforce.

The organisation has continued to play an active role within the Torbay and Devon Safeguarding Adult Partnership (TDSAP), contributing to the delivery of the Partnership's strategic priorities through leadership, participation in multi-agency workstreams, and the implementation of local and national safeguarding learning. This collaborative approach has strengthened safeguarding effectiveness and supported improved outcomes for adults at risk of abuse or neglect.

Alongside safeguarding activity, continued focus has been given to the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, domestic abuse, self-neglect, exploitation, Prevent and complex risk management. Investment in training and workforce development has enhanced practitioner confidence and competence, while quality assurance activity has provided greater oversight of practice and identified opportunities for further improvement.

As Adult Social Care prepares for transition to Torbay Council, safeguarding remains a key area of focus. Arrangements are being developed to maintain statutory compliance, preserve organisational learning and ensure continuity of leadership, governance and safeguarding oversight. Assurance will depend on clear ownership of statutory duties, controls, datasets and improvement actions before and after transfer, supported by defined escalation and reporting arrangements.

Overall, the report provides satisfactory assurance in several safeguarding domains and identifies evidence of effective partnership working and improvement activity. However, the continuing DoLS and Community DoL backlogs, training compliance gaps, incomplete demographic data and transition risks mean that the overall assurance rating remains Limited. These areas require continued oversight and measurable improvement during 2026/27.

1.0 Summary of key risks during 2025/2026

1.1 DoLS and statutory compliance pressures

Ongoing demand and complexity associated with DoLS and Community Deprivation of Liberty cases continue to create risks around timeliness, legal compliance, and the organisation's ability to meet its statutory responsibilities.

1.2 Implementation of AGNI and wider legal changes

National developments, including the AGNI Supreme Court judgment, require significant changes to policy, practice, training, and governance arrangements. Failure to implement these changes effectively could result in legal and compliance risks.

1.3 Workforce capacity, capability and training compliance

Workforce pressures, vacancies, organisational change, and training compliance below target levels may impact the consistency and quality of safeguarding practice and reduce organisational assurance.

1.4 Data quality, digital systems and organisational assurance

Risks relating to data quality, system configuration, reporting, and record management may affect safeguarding oversight, performance monitoring, decision-making, and regulatory assurance**.**

2.0 Culture and Leadership

2.1 Torbay and South Devon NHS Foundation Trust (TSDFT).

Trust Values, Vision, Objectives and Purpose are aligned to Safeguarding / Mental Capacity Act principles. These key messages directly link to the NHS constitution such as:

- Protection of human rights. (Principle 1)
- Safe, high-quality care which focuses on patient experience. Respect, dignity, compassion and care are at the core of how people are treated. (Principle 3)
- Placing the individual at the heart of everything. (Principle 4)
- Working in partnership with other organisations in the interests of our population (Principle 5)
- Informed consent and the Mental Capacity Act (Rights)

2.2 Torbay Council - Vision for Adult Social Care

Our Safeguarding / Mental Capacity Act principles set within with Our Vision for adult social care in Torbay.

- Focus on outcomes and well-being.
- Strength based, co-created and flexible care and support both for individuals and at a community level.
- Proactive and preventative action through early intervention.
- Integrated and coordinated local arrangements.
- Relationship based practice which empowers people to have choice and control over their lives.

2.3 Three examples of how we are putting these into practice include:

- **Mandatory Training** with Safeguarding Adult and Mental Capacity Act (MCA) training offers for all staff.
- **Qualitative feedback from people who use services** and who have experienced safeguarding.
- **Active partnerships** with local, regional and national Safeguarding Adults and MCA/DoLS partners.

3. Legislation and Guidance

During 2025/26, TSDFT continued to deliver Adult Social Care services on behalf of Torbay Council under local Section 75 arrangements, fulfilling delegated safeguarding functions and other statutory responsibilities in accordance with the Care Act 2014 and associated legal frameworks.

3.1 The Care Act 2014

The Care Act 2014 remains the principal legislative framework for adult safeguarding in England. It clarifies the roles and responsibilities of local authorities and partner agencies.

Local Authorities are required to:

- Establish and maintain a Safeguarding Adults Board (SAB) to provide strategic leadership, oversight, and assurance regarding safeguarding arrangements across the local area.
- Undertake, or cause others to undertake, safeguarding enquiries where there is reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves because of those needs.
- Commission Safeguarding Adults Reviews (SARs) in accordance with Section 44 of the Act where statutory criteria are met, to identify learning and improve future practice.
- Co-operate with relevant partner agencies, as defined within Section 6 of the Act, to support the protection and wellbeing of adults at risk.

- Request co-operation from partner agencies, who in turn have a reciprocal duty to work collaboratively with the Local Authority in fulfilling safeguarding responsibilities.

TSDFT and Torbay Council maintain an active and constructive relationship with the Torbay and **South Devon Safeguarding Adults Partnership (TDSAP)**. This engagement supports continuous improvement in safeguarding practice, ensuring that we respond effectively to emerging issues and sector developments, and that safeguarding activity remains person-centred, proportionate, and focused on achieving positive outcomes for adults with care and support needs.

3.2 The Mental Capacity Act 2005 (MCA 2005)

This Act provides a statutory framework for:

- People who lack capacity to make decisions for themselves, or
- People who have capacity and want to prepare for a time in the future when they may lack capacity.
- Who can take best interest decisions, in which situations, and how they should go about this.

The Act is underlined by 5 key principles –

- Principle 1 – A presumption of capacity unless proved otherwise.
- Principle 2 – Individuals must be supported to make their own decisions.
- Principle 3 – People have the right to make unwise decisions.
- Principle 4 – Anything done on behalf of a person who lacks capacity must be undertaken in their best interests.
- Principle 5 – Someone deciding or acting on behalf of a person who lacks capacity must do so in a way that is least restrictive.

3.3 Deprivation of Liberty Safeguards (DOLS)

- The DOLS legal framework is found in Schedule A1 of the Mental Capacity Act 2005. These safeguards are intended to protect the rights, dignity, and freedom of individuals who lack capacity.
- Provides the legal framework for authorising a deprivation of liberty for adults aged 18 and over who lack the mental capacity to consent to the care or treatment arrangements that give rise to the deprivation of liberty.
- Sets out the circumstances in which a deprivation of liberty may be lawfully authorised in hospitals and care homes, ensuring that restrictions are necessary, proportionate, and in the person's best interests.
- Requires a series of statutory assessments to be completed before a deprivation of liberty can be authorised, including assessments of age, mental capacity, mental health, eligibility, no refusals, and best interests.

3.4 Re X Court of Protection Cases (Community Deprivation of Liberty cases)

- The Court of Protection continues to provide the legal framework for authorising deprivations of liberty in community settings through the Re X

process. Applications must demonstrate that the person lacks capacity, that the arrangements are in their best interests, and that any restrictions are necessary and proportionate.

- The process provides judicial oversight and safeguards to protect the rights of individuals who may be deprived of their liberty outside hospital and care home settings.

4.0 Mental Capacity Act / Deprivation of Liberty Safeguards

4.1 Assurance:

Section	Assurance 2025/2026 (Limited/Satisfactory/Significant)	Trend 2024/2025
Mental Capacity Act (Adult Social Care and Health)	Satisfactory	Satisfactory
Deprivation of Liberty (Adult Social Care)	Limited	Limited

4.2 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

During 2025/26, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Court of Protection functions continued to provide essential safeguards for adults who may lack capacity to make decisions about their care, treatment and accommodation. Practice remained informed by the legal framework established through the MCA 2005, DoLS and the Court of Protection's Re X process, ensuring that restrictions on a person's liberty were subject to appropriate assessment, scrutiny and legal authorisation where required.

To support quality and continuous improvements the Adult Social Care Supervisory Body DoLS Team have worked to support compliance with Torbay Councils statutory responsibilities. This has included providing advice and guidance to practitioners, quality assuring assessments and applications, supporting Managing Authorities, and promoting consistent application of the MCA principles across the partnership. Activity also included oversight of DoLS authorisations, Court of Protection applications for individuals living in community settings, and workforce development to strengthen practitioners' knowledge and confidence in applying the legal framework.

During 2025/26, the Adult Social Care Supervisory Body continued to experience significant demand for Deprivation of Liberty Safeguards assessments. At 31 March 2026, the DoLS backlog stood at 544 cases awaiting assessment and authorisation. The most recent position, in August 2026, showed a backlog of 471 cases, a

reduction of 73 cases (13.4%). This demonstrates progress, although demand remains high and continues to reflect national pressures on DoLS services.

The risk arising from the backlog has remained subject to robust governance and oversight arrangements throughout the year. Performance, risk, and backlog management are routinely reported through TDSFT and Torbay Council governance structures and continue to feature on both organisational risk registers. This has ensured senior leadership oversight of legal, operational and reputational risks associated with delayed authorisations.

During the year, the service implemented a redesign of the Supervisory Body function aimed at improving resilience and increasing assessment capacity. A key element of this approach has been the expanded use of Independent Best Interests Assessors (IBIAs), enabling available resources to be utilised more effectively and supporting increased assessment activity. Robust quality assurance arrangements have been established, including verification of assessor qualifications, indemnity and training requirements, alongside case audits undertaken by the Mental Capacity Act Lead to ensure compliance with legislation, case law and national practice guidance.

The service continues to prioritise cases using national ADASS risk-based triage guidance, with all referrals subject to review and reprioritisation where circumstances change. Weekly safety huddles support allocation decisions, monitor high-risk applications and review progress against the backlog. Additional efficiencies have been delivered through the use of desktop and remote assessments where appropriate, whilst maintaining face-to-face assessments for higher-risk or more complex cases.

Further assurance is provided through regular monitoring of Independent Mental Capacity Advocacy (IMCA) provision, Section 12 doctor capacity, legal challenges under Section 21A, and the ongoing cleansing and validation of DoLS data. Signatory training has also been strengthened to support lawful authorisation processes and improve operational resilience.

Despite these measures, significant pressures remain. Not all referrals can currently be allocated within reasonable timescales due to available resources, and access to Mental Health Assessors, legal advocacy services and Independent Best Interests Assessors continues to constrain throughput. Consequently, there remains a risk of breaches of Article 5 rights where individuals are deprived of their liberty without a timely lawful authorisation.

Looking forward to 2026/2027 the service is responding proactively to emerging AGNI case law and changes in legal interpretation by reviewing existing cases to determine whether individuals continued to meet the threshold for DoLS authorisation. This work will support a more accurate understanding of the backlog and informed future service planning

The DoLS service has a well-established governance framework, comprehensive risk management arrangements and a clear improvement plan focused on reducing

the backlog through targeted investment, effective triage, independent assessor capacity and service redesign. **Assurance for 2025/26 is therefore assessed as Limited**, reflecting continued oversight and mitigation activity, whilst recognising that the scale of the backlog continues to present a significant statutory and operational challenge.

4.3 Re X Court of Protection Cases (Community Deprivation of Liberty cases)

During 2025/26, the Council and TSDFT undertook significant work to establish a safe, legally compliant and sustainable approach to managing Community Deprivation of Liberty (Com DoL) cases, which require authorisation through the Court of Protection and sit outside the statutory DoLS framework. This followed a significant increase in demand and a backlog of approximately **110 cases awaiting allocation**.

A comprehensive review of all outstanding cases was undertaken to validate demand, identify cases that no longer required progression, and ensure resources were focused on individuals who continued to meet the legal threshold for authorisation. This work strengthened governance, oversight and performance monitoring arrangements, improved the quality and timeliness of decision-making, and ensured that Court of Protection applications were supported by current, proportionate and evidence-based assessments.

Dedicated processes, enhanced case tracking, management oversight and regular reporting were introduced to improve assurance and support risk-based prioritisation. Additional funding has also been secured for 2026/27 to increase assessment capacity and support backlog reduction through targeted assessment activity, including the commissioning of independent capacity and best interest assessments where required.

Looking ahead, service planning will continue to be shaped by the implications of the Attorney General for Northern Ireland's Reference (Deprivation of Liberty) [2026] UKSC 16 (AGNI) judgment (see para 4.45 below). The changing legal framework is expected to reduce the number of cases requiring Court of Protection authorisation, while supporting a more proportionate approach to identifying and managing community deprivations of liberty. Ongoing review of existing cases will help ensure resources are directed to those who continue to require legal authorisation and safeguard against the risk of unlawful deprivation of liberty.

While challenges remain, particularly in relation to Court of Protection timescales and the recruitment of specialist assessment resources, TSDFT and Torbay Council have taken significant steps to strengthen their control framework and mitigate the risk of unlawful deprivation of liberty. Assurance is therefore assessed as Limited, with improvement activity ongoing and plans in place to reduce the backlog, increase assessment capacity and strengthen compliance with Mental Capacity Act safeguards.

4.4 Managing Authority (Health)

Throughout 2025/26, ongoing support has been provided to the Health Managing Authority to strengthen the identification and oversight of potential deprivations of liberty. This has included supporting staff to recognise when a DoLS authorisation or review may be required, ensuring appropriate escalation and timely requests for review where circumstances change. Continued emphasis has also been placed on maintaining the least restrictive approach, encouraging regular consideration of whether restrictions remain necessary and proportionate and whether less restrictive alternatives can safely meet the person's needs. This ongoing support helps embed Mental Capacity Act and DoLS principles within practice and strengthens oversight of restrictions affecting people who may lack capacity to consent to their care arrangements.

4.5 Liberty Protection Safeguards (LPS)

Recognising the developing legal landscape, the Supervisory Body began preparatory work in response to emerging case law and anticipated changes affecting deprivation of liberty practice, including the proposed move to the Liberty Protection Safeguards. This included reviewing local policies and procedures, strengthening governance arrangements, working collaboratively through regional and One Devon networks, and considering the implications for practice, recording requirements and workforce development.

The LPS remains paused nationally, and the DoLS framework continues to operate alongside Court of Protection authorisations for community-based deprivations of liberty. In October 2025, the Government announced that it intends to launch a formal consultation during 2026/2027. The consultation will seek views from people with lived experience, families, carers, social workers, health professionals and other stakeholders.

In response to the current hiatus the Safeguarding Adults and MCA/DoLS Team continued to monitor national developments and maintain readiness for any future implementation of LPS, whilst ensuring that existing statutory safeguards remained effective in protecting the rights and freedoms of adults who lack capacity to consent to their care and support arrangements.

4.6 A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 [2026] UKSC 16

The AGNI judgment clarifies the legal approach to determining whether arrangements amount to a deprivation of liberty under Article 5. Its implications require careful review of relevant policies, procedures, training, documentation and individual cases across health and social care. Implementation work should ensure that decisions remain person-centred, legally compliant and supported by clear evidence of the person's circumstances, wishes and feelings.

The MCA/DoLS Team will lead a programme of work to support implementation, including revised guidance, policy updates, practitioner training, system development and enhanced partnership arrangements. Working collaboratively across Devon, the

partnership will seek to review the impact of AGNI to ensure consistency of practice, legal compliance and safeguard the rights of adults who lack capacity.

The AGNI judgment may change the number of DoLS and Community DoL cases that meet the legal threshold for deprivation of liberty under Article 5. The scale of any change will depend on the review of individual circumstances and the application of updated national guidance. This places increased emphasis on robust Care Act and MCA practice, professional judgement and clear documentation to ensure that individuals continue to receive appropriate legal protections.

To support this, the Safeguarding Adults and MCA/DoLS Team plans to prioritise support to Managing Authorities during 2026/2027 to strengthen their decision-making, and to maintain a focus on person-centred care and ensure that all restrictions are necessary, proportionate and clearly evidenced.

4.7 MCA/DoLS Training

Throughout 2025/26, TSDFT continued to deliver its in-house Safeguarding Adults and Mental Capacity Act (MCA) training programme, providing a responsive approach to legislative and practice developments. This offer has been well received by Adult Social Care staff and partner agencies.

The Safeguarding Adults and MCA/DoLS Team supported services to strengthen application of the MCA, improve recording standards, and promote defensible decision-making, with particular emphasis on capacity, best interests, necessity, proportionality, and Articles 5 and 8 human rights considerations. During the year, the team also prepared services for the implications of the AGNI judgment through guidance, advice, supervision, and practice support.

The teams have provided strong leadership during a period of significant legal and operational change, supporting policy development, workforce capability, and system-wide assurance. This has helped maintain lawful, person-centred practice across health and adult social care services.

Training continued to be delivered at scale across the integrated workforce. Whilst health and Adult Social Care attendance data cannot currently be separated, learning has focused on strengthening understanding and application of MCA and DoLS requirements, including developments arising from the AGNI judgment.

Assurance regarding the impact of training is derived not only from attendance figures but through audits, supervision, case reviews, professional advice requests, and practice discussions. These activities demonstrate the ongoing embedding of learning into practice and support improvements in capacity assessments, best interest decision-making, and the lawful use of restrictions and deprivation of liberty arrangements.

4.8 Case Management System (Liquid Logic)

Considerable investment has been made during 2025/26 in the development of new operational processes to support digital infrastructure for adult social care. The DoLS Team played a central role in the review and redesign of CMS systems (Liquid

Logic) during this period, with implementation and associated benefits realisation to be reported during 2026/27.

As part of this programme, risks relating to data quality, legacy records, and the safe transfer of information between systems have been identified and closely monitored. These risks have been formally escalated to programme leads and the Divisional Management Team (DMT) to ensure appropriate oversight, mitigation and governance.

Ongoing work during 2026/27 will focus on embedding the new arrangements, strengthening data assurance, and ensuring that operational and digital processes support a legally compliant, sustainable and efficient deprivation of liberty service.

4.9 Electronic Patient Record (EPIC)

During 2025/26, the Safeguarding Adults/Mental Capacity Act (SGA/MCA) Team played an active role in supporting the preparation and implementation of the Trust's new electronic patient record. This included reviewing and contributing to the development of safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards documentation and pathways to ensure that relevant legal and practice requirements were appropriately reflected within the new system.

The Team supported the transition of existing processes, identified areas requiring amendment, and provided specialist advice to help ensure that staff could appropriately record, identify and escalate safeguarding and MCA/DoLS considerations. Alongside system development, the Team supported staff preparedness through guidance, education and practical implementation support. This work provided assurance that safeguarding, mental capacity and deprivation of liberty considerations remained integral to the transition to the new electronic patient record, supporting consistent documentation, appropriate escalation and safe, legally informed practice.

5.0 Regulation

5.1 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires providers to protect people from abuse, neglect, discrimination, and improper treatment. This includes ensuring that any restrictions on an individual's liberty are lawful, proportionate, and compliant with the Mental Capacity Act 2005. Compliance with Regulation 13 supports the delivery of safe, person-centred, and legally compliant care.

5.2 Adult Social Care CQC Assurance (Inspection)

The Health and Care Act 2022 introduced a new duty for CQC to assess how local authorities meet their adult social care responsibilities under Part 1 of the Care Act

2014. CQC's assessment considers how effectively councils work with people and partners to provide adult social care and support.
CQC uses a four-point rating system: Outstanding, Good, Requires Improvement and Inadequate. Its assessment of **Torbay** Council's adult social care functions, published in December 2025, rated the Council Good overall.

The inspection covered four main themes:

- **Theme 1: Working with people** – looking at assessing needs, supporting people to live healthier lives, Equity in experiences and outcomes
- **Theme 2: Providing Support** – Care provision, integration, and continuity, Partnerships and communities
- **Theme 3: Ensuring Safety** – Safe systems, pathways and transitions
- **Theme 4: Leadership and Workforce** – Governance, management and sustainability, Learning, improvement and innovation

The CQC report highlights both strengths and areas for improvement. Safeguarding and Safety highlighted the strength of our *"effective safeguarding systems"* and *"multi-agency partnerships"*.

5.3 Other Statutory Frameworks

In addition to the Care Act 2014 and Mental Capacity Act 2005, safeguarding adults practice is informed by a range of statutory and regulatory frameworks that support the protection of adults at risk, promote individual rights, and strengthen partnership working.

These include:

- Human Rights Act 1998
- Equality Act 2010
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Safeguarding Vulnerable Groups Act 2006
- Mental Health Act 1983 (as amended)
- Modern Slavery Act 2015
- Serious Crime Act 2015
- Counter-Terrorism and Security Act 2015 (Prevent Duty)
- Homelessness Reduction Act 2017
- Domestic Abuse Act 2021
- Data Protection Act 2018 and UK GDPR

6.0 Safeguarding Adults

6.1 Assurance:

Section	Assurance 2025/2026 (Limited/Satisfactory/Significant)	Trend 2024/2025

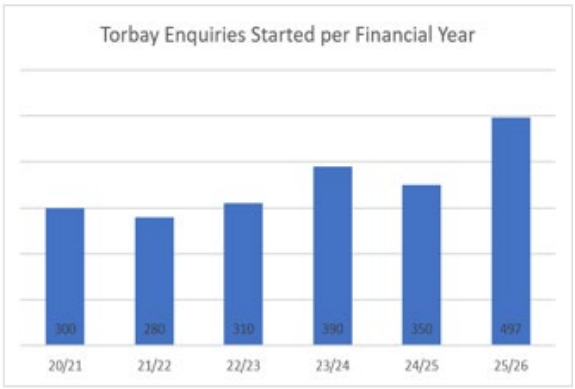
Safeguarding Adults (Adult Social Care and Health)	Satisfactory	Satisfactory

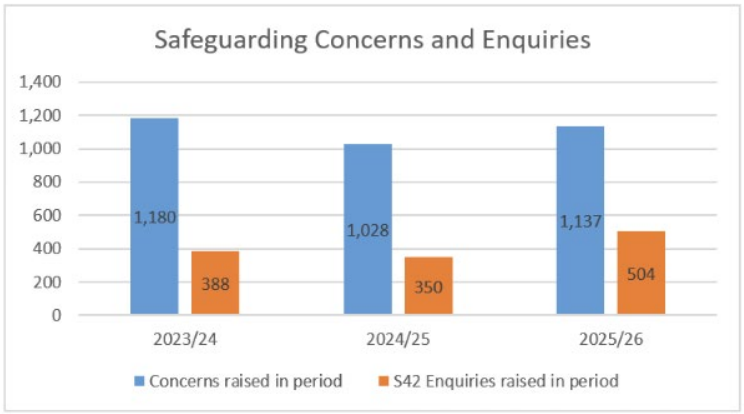
6.2 Safeguarding Adult data 2025-2026

This section presents the key safeguarding performance data for 2025/26, outlining trends in safeguarding activity, the effectiveness of enquiry management and progress against key performance indicators. Where more recent 2026/27 information is included, it is identified separately to show the current trajectory after the year end.

6.3 Safeguarding enquiries commenced

The number of safeguarding enquiries commenced in Torbay has shown an overall upward trend over the past six years, increasing from 300 in 2020/21 to 497 in 2025/26. Following relatively stable activity between 2020/21 and 2022/23, enquiries increased during 2023/24 and, despite a slight reduction in 2024/25, rose significantly in 2025/26 to the highest level recorded during the reporting period.





From April 2025 to March 2026 there were 1,137 safeguarding adult Concerns received which is a 10.6% increase on the previous financial year.

The number of concerns which proceeded to Care Act Section 42 Enquiry increased by 44.0% to 504.

The conversion rate from Concerns to Section 42 Enquiries increased to 44.3%.

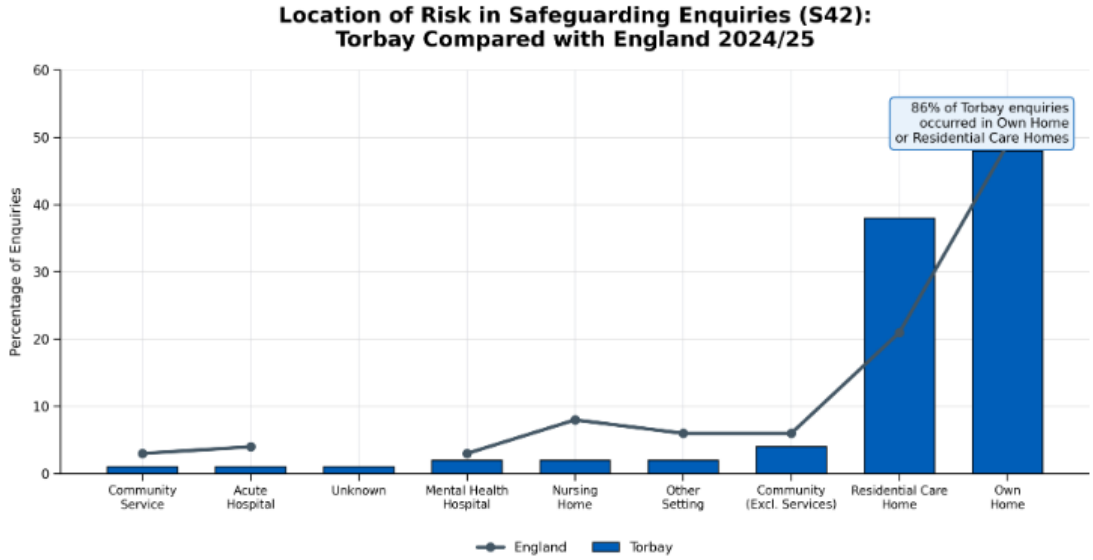
The most common types of abuse reported were 'Neglect and Acts of Omission' (24%), 'Organisational' (15%) and 'Physical' (15%).

The increase reflects continued vigilance across partner agencies in identifying and responding to safeguarding concerns, alongside increasing demand and complexity within adult safeguarding. The higher volume of enquiries has required ongoing focus on operational capacity, timely decision-making, and effective multi-agency working to ensure adults at risk receive an appropriate safeguarding response. 2025/26 saw a substantial increase in safeguarding enquiries, with 497 enquiries commenced, representing the highest level of activity recorded over the six-year period.

6.4 Location of risk in safeguarding enquiries (Section 42) — 2024/25 comparator data

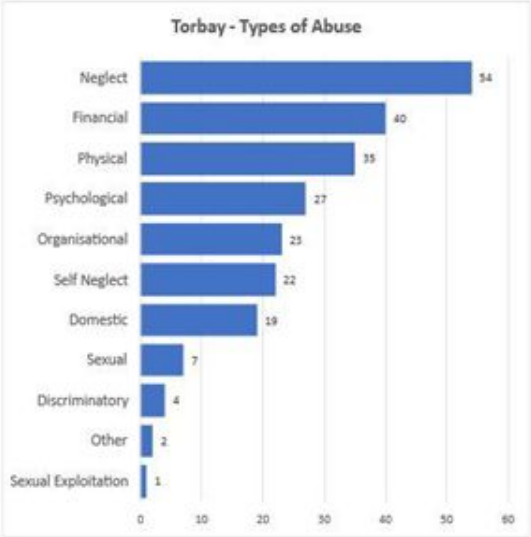
The majority of safeguarding enquiries in Torbay arose within an individual's own home (48%) or a residential care home (38%), together accounting for 86% of all enquiries. The proportion of enquiries relating to risks in an individual's own home was comparable to the England average (49%), whilst Torbay recorded a higher proportion of enquiries within residential care homes (38% compared with 21% nationally).

This profile reinforces the importance of maintaining effective safeguarding arrangements, quality assurance, and provider oversight across residential care settings, alongside continued work to support adults at risk within their own homes.



6.5 Types of abuse reported in Torbay

In Torbay, neglect continues to be the most commonly reported type of abuse, followed by financial abuse and physical abuse. Financial abuse enquiries increased from 20 in Quarter 4 of 2025/26; the relevant comparison period and current number should be stated alongside this figure to demonstrate the scale and timing of the change.

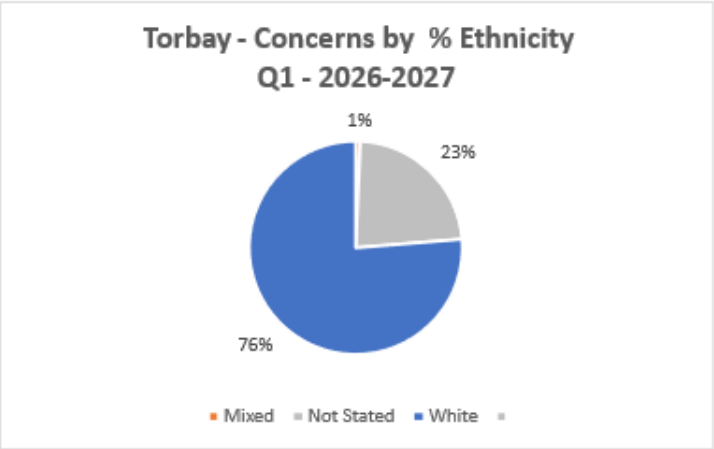


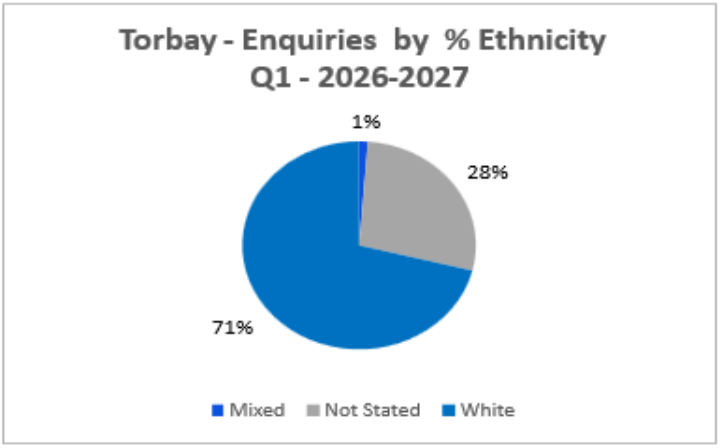
6.6 Financial abuse

The increase in financial abuse concerns during 2025/26 was largely attributable to referrals arising from a large-scale safeguarding enquiry within a provider setting. The enquiry identified financial errors affecting a number of individuals; however, there was no evidence of intentional harm or financial exploitation. All affected individuals were reimbursed and provided with appropriate compensation, and additional safeguards were implemented through Mental Capacity Assessments and, where required, Best Interest decisions. Whilst this activity contributed to a higher number of recorded financial abuse concerns in 2025/26, early indications from 2026/27 suggest reporting levels are returning towards those seen prior to the enquiry. Ongoing assurance activity will continue to monitor practice and ensure learning remains embedded across the provider sector.

6.7 Ethnicity recording

Understanding who accesses safeguarding support is essential to ensuring equitable and inclusive practice. However, the completeness of ethnicity data remains a challenge. During Quarter 1 of 2026/27, ethnicity was recorded as Not Stated in 23% of safeguarding concerns and 28% of safeguarding enquiries.
The implementation of new health and social care recording systems during the reporting period limited opportunities to strengthen ethnicity recording within legacy systems. As these systems become embedded in practice, improving the quality and completeness of demographic data will remain a priority, enabling more robust analysis of safeguarding activity and outcomes across different communities.
Improving ethnicity recording remains a priority to support a better understanding of the populations accessing safeguarding services and to provide assurance that safeguarding responses are equitable and inclusive.





6.8 Qualitative feedback

Understanding the experiences of people involved in adult safeguarding processes is an important aspect of our service improvement and quality assurance. In Torbay, we commission an independent advocacy provider to undertake feedback and discovery interviews with individuals, or their representatives, who consent to sharing their experiences. This qualitative feedback provides valuable insight into how safeguarding interventions are experienced, helping to identify areas of good practice, inform service development, and support continuous improvement in safeguarding outcomes.

We actively review and use this information to inform our quality assurance activity, drive continuous improvement, and provide assurance that safeguarding practice reflects the principles of **Making Safeguarding Personal (MSP)**.

6.9 Management of Safeguarding Adults level 3 training

In September 2024, the Trust brought the delivery of Safeguarding Adults Level 3 training in-house across both health and adult social care services. This strategic change was made to enable a more targeted and responsive approach to training delivery, ensuring that content is aligned to local priorities, emerging risks,

organisational learning and lessons arising from Safeguarding Adult Reviews (SARs). Delivery of the revised programme commenced in January 2025 and has enabled the programme to incorporate learning from SARs, changes in legislation and policy, and emerging themes from local safeguarding activity, with a stronger focus on professional curiosity, defensible decision-making, risk management and Making Safeguarding Personal (MSP).

The organisation's compliance target for safeguarding training is 85%. Compliance for Levels 1 and 2 remains above target at 94.8% and 89.1% respectively; however, Level 3 compliance currently stands at 65.4%, representing a continuing challenge across the wider Trust. This reflects workforce pressures, competing operational demands and difficulties releasing clinical staff from frontline services to attend training. Despite the lower compliance rate, the move to an in-house model has enhanced the quality and local relevance of the training delivered.

Compliance at Levels 4, 5 and 6 also remains below the corporate target. At Q2 2026, compliance is 80.0% for Level 4, 71.4% for Level 5 and 42.9% for Level 6. Assurance activity has identified that these percentages are significantly influenced by the relatively small numbers of staff required to complete training at these specialist levels, meaning that vacancies, staff turnover, role changes and periods of leave can have a disproportionate impact on reported performance. The risk associated with non-compliance is assessed as moderate and is mitigated through professional registration requirements, safeguarding supervision, management oversight and access to specialist safeguarding advice.

Safeguarding Adults Level 3 compliance is 65.4% against the organisational target of 85%, creating a material workforce capability gap. Levels 4, 5 and 6 are also below target at 80.0%, 71.4% and 42.9% respectively at Q2 2026. Recovery actions include named follow-up with staff and managers, incorporation of training requirements into induction and workforce planning, increased access to training and strengthened local leadership oversight. Progress will be monitored against an agreed monthly trajectory, with exceptions escalated through the relevant governance route where compliance does not improve or operational release remains a barrier.

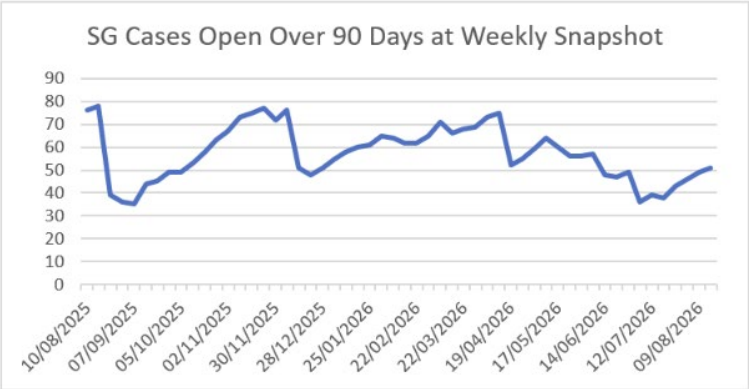
6.10 Management of completion of s.42(2) Care Act enquiries

The timely completion of safeguarding enquiries continues to be an important aspect of our safeguarding practice and quality assurance activity. During 2025/26, we implemented enhanced oversight across operational teams and the Safeguarding Professional Practice Team with planned work to reduce the number of enquiries remaining open beyond the local 90-day timescale. This activity was undertaken in direct response to Torbay Council's CQC improvement plan and reflected our commitment to ensuring that safeguarding concerns are progressed and resolved in a timely, effective, and person-centred way.

This has improved the timeliness of safeguarding interventions, strengthened accountability, and helped ensure that adults and their representatives receive a more responsive service focused on achieving positive outcomes. Whilst recognising

that a small number of complex enquiries will require extended timescales, the overall reduction provides assurance that safeguarding concerns are being progressed and concluded more effectively.

To support this improvement, we strengthened performance monitoring, enhanced management oversight, and provided targeted support to practitioners.



Enhanced performance monitoring and management oversight reduced the number of safeguarding enquiries open for more than 90 days, with targeted support provided to practitioners and continued review of complex and outlier cases.

Between 10 August 2025 and 16 August 2026, the number of safeguarding enquiries open for more than 90 days reduced by 33% to 51. By Q2 2026/27, this had reduced further to 25 cases. The 2026/27 threshold is no more than 25 cases open beyond 90 days. Performance has therefore reached the current threshold, but continued oversight is required to demonstrate that the improvement is sustained and that complex cases do not experience avoidable drift.

Looking ahead into 2026/2027, performance is moving in the right direction, with **the number of safeguarding enquiries open for more than 90 days reducing from 42 cases in June 2026 to 25 cases, a 40.5% reduction at Q2.** This improvement brings performance in line with our 2026/27 KPI target and demonstrates sustained improvement in the timely completion of safeguarding enquiries, supported by strengthened management oversight and targeted service improvement activity.

The Safeguarding Professional Practice Team will continue to provide oversight of outlier cases to ensure there is no unnecessary drift or delay in progressing enquiries, and that adults continue to receive a timely and proportionate safeguarding response.

This approach supports continued accountability, promotes effective safeguarding practice, and helps ensure positive outcomes for people with care and support needs.

6.11 Torbay and South Devon Safeguarding Adults Partnership (TDSAP)

The TSDFT working alongside Torbay Council plays a significant role in the governance and operational activities of the Torbay and South Devon Safeguarding

Adults Partnership (TDSAP) and we are committed to working collaboratively with partner agencies to safeguard adults across Torbay and South Devon.

The core objective of TDSAP and Torbay Council, as set out in Section 43(2) of the Care Act 2014, is to help and protect adults who:

- Have care and support needs;
- Are experiencing, or are at risk of, abuse or neglect; and
- As a result of their care and support needs, are unable to protect themselves from the risk of, or experience of, abuse or neglect.



TDSAP Structure 2025/2026

6.12 Partnership priorities

The TDSAP Business Activity Plan 2025-2027 is structured around several strategic priorities aimed at strengthening safeguarding practice, embedding learning, and promoting awareness, engagement, and inclusion.

TDSAP priorities 2025-2027 include:

- Strong and consistent strategic oversight
- Improved quality of frontline practice
- Strong multi-agency accountability
- Measurable reduction in risk
- Increased practitioner confidence and capability
- Strong Board oversight and decision-making

The Operational Delivery Group (ODG) oversees delivery of the plan; monitors progress against agreed objectives and provides assurance to the TDSAP Board.

During 2025/26, TSDFT and Torbay Council have continued to support the delivery of TDSAP priorities through leadership, workforce development, quality assurance activity, service improvement initiatives, and participation in partnership governance and workstreams.

Going forward through 2026/27 and 2027/28, as part of the transition of Adult Social Care functions from TSDFT to Torbay Council, it will be necessary to review our safeguarding partnership arrangements to ensure continuity of membership, representation and delivery of key safeguarding activities. This will support the maintenance of effective attendance at strategic and operational forums, provide clear alignment of governance responsibilities, and ensure TSDFT and Torbay Council continue to contribute fully to safeguarding partnership priorities and objectives.

Priority 1
Seek assurance from partners in relation to practice improvements in key risk areas

Throughout 2025/26, TSDFT and Torbay Council continued to strengthen safeguarding practice through workforce development, quality assurance and partnership working. **Making Safeguarding Personal** remained central to safeguarding activity, ensuring that individuals' views, wishes and desired outcomes informed safeguarding interventions.

Revised safeguarding training has enhanced staff knowledge and confidence, while participation in TDSAP task and finish groups has supported the development of improved guidance and tools across the partnership, this has included a plan to review our 'whole service' safeguarding policy with our partners in TDSAP and Devon Council. This work is currently underway during 2026/2027 with completion planned for circa Q3 2026.

Audit activity continues in 2025/2026, including case-specific reviews and MCA and DoLS audits. This has provided assurance regarding the quality of practice and informed ongoing service improvement.

Collectively, these activities demonstrate TSDFT and Torbay Council's commitment to continuous improvement, person-centred practice, and effective safeguarding arrangements for adults with care and support needs.

Priority 2
Seek assurance from partners that learning from SARs is embedded into practice

Significant progress has been made in embedding learning from Safeguarding Adults Reviews (SARs) into frontline practice, with assurance activity and audit reporting providing evidence of the implementation of SAR recommendations.

- During 2025/26, we were effective in completing all organisationally relevant actions arising from local SARs, ensuring we could provide TDSAP assurance that learning and recommendations were embedded through improvements to

policy, practice and workforce development. Achieving full completion of SAR action plans is a key milestone and has been acknowledged by TDSAP as a positive example of our commitment to learning from experience and strengthening safeguarding outcomes.

- Another key achievement has been the implementation of the **Multi-Agency Risk Management Meeting (MARMM)** process, strengthening multi-agency collaboration, information sharing, and the coordinated management of adults experiencing multiple and complex risks.
- Learning has been reinforced through legal briefings, dissemination of practice guidance, and the integration of SAR findings into safeguarding training programmes. In doing this, we have effectively utilised the seven-minute briefing model to support learning.

Collectively, these activities demonstrate TSDFT and Torbay Council's commitment to learning, continuous improvement, and ensuring that lessons from Safeguarding Adults Reviews result in meaningful and sustained improvements in safeguarding practice and outcomes.

Priority 3
Improve awareness, engagement and inclusion

- Improving awareness, engagement, and inclusion has remained a key priority throughout 2025/26.
- Torbay has contributed to TDSAP activity aimed at strengthening equality, diversity, and inclusion within safeguarding practice.
- Feedback from Safeguarding Quality Checkers has continued to provide valuable insight into the experiences of people accessing safeguarding services, helping to inform service improvements and reinforce a person-centred approach.
- Ongoing work to strengthen Mental Capacity Act (MCA) compliance has supported practitioners to make lawful, proportionate, and person-centred decisions, enhancing both the quality and inclusiveness of safeguarding practice.

Collectively, these activities demonstrate TSDFT and Torbay Council's commitment to ensuring safeguarding services remain inclusive, responsive to people's experiences, and focused on achieving positive outcomes for adults with care and support needs.

6.13 How we are driving improvement

TSDFT and Torbay Council have worked jointly to support the delivery of TDSAP priorities through quality assurance, workforce development, partnership working, and service improvement activity.

Key areas of focus during 2025/26 have included:

- Delivery of an enhanced in-house safeguarding adults training programme aligned to local priorities, SAR learning, emerging risks, and legislative developments.
- Ongoing monitoring of safeguarding performance and Section 42 enquiry activity to support quality assurance and service improvement.
- Use of feedback from Safeguarding Quality Checkers to inform service development and strengthen person-centred safeguarding practice.
- Leadership and participation in TDSAP governance, strategic workstreams, and partnership improvement activity.
- Implementation of changes arising from the AGNI judgment and continued development of Mental Capacity Act and deprivation of liberty practice.
- Strengthening the TSDFT and Torbay Council's response to domestic abuse, Prevent, modern slavery, and other emerging safeguarding risks through workforce development and partnership working.
- Provision of clinical and professional safeguarding supervision to support reflective practice, professional development, and effective decision-making.
- Support to Adult Social Care assurance and improvement activity pre and post Care Quality Commission (CQC) Local Authority Assurance.

Collectively, these activities demonstrate TSDFT and Torbay Council's commitment to continuous improvement, effective partnership working, and the delivery of safe, person-centred safeguarding services.

6.14 Professional practice - Supervision

Clinical and professional safeguarding supervision remains an important component of the TSDFT and Torbay Council's safeguarding framework, providing practitioners with opportunities for reflection, learning, and support when managing complex safeguarding concerns. Supervision promotes professional curiosity, defensible decision-making, application of the Mental Capacity Act, and the embedding of learning from Safeguarding Adults Reviews, audits, and significant incidents. Available across health and adult social care services, safeguarding supervision contributes to workforce wellbeing, professional confidence, and improved outcomes for adults with care and support needs.

We continue to use organisational performance data and quality assurance activity to monitor the delivery and effectiveness of supervision across Adult Social Care.

Going into 2026/27, it has been agreed that Torbay Council will commission an independent audit of TSDFT supervision and appraisal arrangements to provide

additional assurance regarding compliance, quality and impact. The findings from this audit will inform the development and implementation of a new Supervision Policy, including standardised supervision recording tools, this work will be led by the new Principal Social Worker (PSW) for Adult Social Care (Torbay Council) during 2026/27.

The aim in 2026/2027 will be to strengthen the consistency, quality and evidencing of professional supervision discussions, decision-making and outcomes. It will support improved oversight, promote reflective practice, and provide greater assurance that supervision is effectively supporting professional development, practice standards and safeguarding responsibilities. The Policy will enable more consistent approach to practice including recording and reporting of supervision activity, supporting ongoing quality assurance and service improvement.

7.0 Delivering Improvement

The following section outlines our safeguarding priorities during 2025/26 and provides examples of the actions taken to support delivery and continuous improvement.

7.1 Domestic Abuse and Sexual Violence (DASV)

Section	Assurance 2025/2026 (Limited/Satisfactory/Significant)	Trend 2024/2025
Domestic Abuse (Health)	Satisfactory	Satisfactory

TSDFT and Torbay Council continue to be committed to strengthening their response to Domestic Abuse and Sexual Violence (DASV), ensuring that both people at risk and staff can access timely support, specialist advice and appropriate safeguarding interventions. Key priorities include improving workforce awareness of domestic abuse, embedding mandatory training, supporting national recommendations, and maintaining strong partnership arrangements across the wider health and social care system, Including TDSAP.

A significant development during the reporting period has been the continued integration of a Health Independent Domestic Violence Advocate (IDVA) within Trust services. The Health IDVA provides specialist expertise, advice and support to patients experiencing, or at risk of, domestic abuse, while also acting as a valuable resource for staff managing complex cases. The role has strengthened pathways between healthcare services and community-based support, helping to improve identification, risk assessment, safety planning and access to specialist interventions.

During 2025/2026 TSDFT and Torbay Council have maintained engagement within local multi-agency domestic abuse arrangements and continue to contribute to strategic and operational priorities across Torbay and South Devon. This includes

regular representation at **Multi-Agency Risk Assessment Conferences** (MARAC), participation in MARAC governance arrangements, and active involvement in both executive and operational **Domestic Abuse Steering Groups**.

Through this partnership approach, TSDFT and Torbay Council gain increased assurance that high-risk domestic abuse cases are identified, coordinated and responded to effectively, with clear oversight of risk, decision-making and outcomes. This collaborative approach strengthens multi-agency accountability, supports the delivery of coordinated responses to domestic abuse, and contributes to the wider safeguarding agenda across the system.

During 2025/26, focused work was undertaken to improve workforce knowledge, confidence and access to domestic abuse resources. A comprehensive domestic abuse training framework was available to all staff through the HIVE learning platform, supported by targeted awareness campaigns, internal communications, screensavers, bulletins and regular information updates to Adult Social Care teams. Bespoke domestic abuse awareness sessions were also offered to services including Adult Social Care, strengthening understanding of identification, enquiry, referral pathways and safeguarding responsibilities.

The Health IDVA continues to provide visible and accessible support within frontline services through regular drop-in sessions in high-risk areas. Alongside this, work is progressing to further strengthen the TSDFT's training offer, including the development of essential-to-role domestic abuse training requirements for key staff groups. TSDFT's also continues to review and update its domestic abuse policies for both patients and employees to ensure that organisational arrangements remain aligned with current legislation, national guidance and best practice.

Overall, the TSDFT has continued to strengthen its approach to domestic abuse through increased specialist provision, enhanced workforce development, robust multi-agency engagement and ongoing policy improvement. This work supports earlier identification of abuse, improved outcomes for victims and survivors, and increased organisational assurance that domestic abuse is recognised and responded to effectively across all services.

7.2 Prevent

Section	Assurance 2025/2026 (Limited/Satisfactory/Significant)	Trend 2024/2025
Prevent (Adult Social Care and Health)	Satisfactory	Satisfactory

During 2025/2026 TSDFT and Torbay Council continued to work closely with partners across Devon and Torbay to deliver its statutory responsibilities under the Prevent Duty. Both organisations are active members of the Torbay and Devon Prevent Partnership arrangements. Prevent is embedded within the TSDFT and Torbay Council's safeguarding frameworks, supporting staff to recognise vulnerability to radicalisation, understand referral pathways and contribute to wider safeguarding responses aimed at preventing individuals from being drawn into terrorism or extremist activity. Throughout the last year, the TSDFT and Torbay

Council have maintained strong partnership working through attendance at Prevent Partnership Boards, Channel Panels and Community Safety Partnership meetings, ensuring that local and national priorities are reflected within organisational practice.

A key area of focus during the year has been workforce development and organisational assurance. Prevent training compliance has remained consistently above national targets, providing assurance that staff have access to the knowledge and skills required to identify, respond to and escalate concerns appropriately. In line with the emerging One Devon approach and recommendations arising from the national Prevent review, TSDFT has transitioned to a three-year renewal cycle for Prevent training. This provides a sustainable and proportionate model for maintaining staff awareness whilst reducing unnecessary training burden and ensuring continued compliance with national expectations. The revised approach supports consistent practice across the wider Devon and Torbay system and strengthens organisational assurance that staff knowledge remains current.

During 2025/2026 TSDFT continued to review its Prevent policy and training framework to ensure alignment with NHS England requirements, national guidance and emerging legislation. Alongside formal training, staff have access to a range of awareness resources, including regular communications, information bulletins and safeguarding support, helping to reinforce key messages and maintain confidence in referral and escalation processes.

National and regional intelligence indicates that whilst overall Prevent referrals across Devon and Torbay have reduced, the proportion originating from health services has increased. This reflects growing awareness among healthcare staff, stronger safeguarding links and increased confidence in recognising vulnerabilities associated with radicalisation. Emerging themes continue to demonstrate that concerns are often linked to vulnerability, social isolation, mental health needs or a fascination with extreme violence, rather than a clearly defined ideological position. As a result, health services play an increasingly important role in providing professional insight, early intervention and safeguarding support as part of a wider multi-agency response.

TSDFT and Torbay Council continued to contribute actively to local Prevent and Channel arrangements, supporting risk assessment and management through information sharing, professional challenge and partnership working. Close collaboration with Community Safety Partnerships, attendance at Channel Panels and contribution to the health response to the Counter Terrorism Local Profile strengthened system-wide assurance and supported a coordinated approach to emerging risks.

Overall, during 2025/26, TSDFT worked closely with its partners, including Torbay Council, to meet national Prevent requirements and continued to demonstrate a mature and proactive approach to Prevent governance, workforce development and partnership working. Looking ahead to 2026/27, priorities include embedding the revised three-year training model, completing policy and procedural updates,

maintaining high levels of staff awareness, and ensuring local Prevent arrangements remain responsive to emerging threats, risks and national developments. These activities provide ongoing assurance that the organisation is well placed to fulfil its Prevent responsibilities and support effective safeguarding across the system.

7.3 Modern Slavery

To ensure staff have access to the training, guidance, and resources required to recognise, respond to, and report concerns relating to modern slavery and human trafficking.

Modern slavery remains a significant safeguarding concern that can affect individuals from all backgrounds, often targeting those experiencing vulnerability, social exclusion, exploitation, homelessness, or poor mental health. Health and social care professionals play an important role in recognising indicators of exploitation and ensuring that concerns are identified and acted upon appropriately. During 2025/26, modern slavery awareness continued to be embedded within safeguarding adults training, supported by guidance, resources, and partnership working. The TSDFT also monitored emerging national developments relating to the identification and support of victims to ensure readiness for future changes in policy and practice.

During 2025/26, TSDFT supported local and regional efforts to tackle modern slavery through:

- Membership of the Devon and Cornwall Anti-Slavery Partnership.
- Inclusion of modern slavery awareness within safeguarding training programmes.
- A dedicated Modern Slavery SharePoint resource for staff.

Whilst the TSDFT and Torbay Council have remained an active member of the Devon and Cornwall Anti-Slavery Partnership, attendance at some partnership meetings has been affected by workforce changes during the reporting period. During 2026/27, representation across safeguarding partnership arrangements will be reviewed as part of the transition of Adult Social Care functions from TSDFT to Torbay Council, ensuring continued engagement in key safeguarding forums and effective contribution to the wider anti-slavery and exploitation agenda.

Through these activities, TSDFT and Torbay Council have continued to support the wider safeguarding system in identifying, preventing, and responding to modern slavery, whilst promoting awareness and access to appropriate support for victims of exploitation.

8.0 Internal Quality Assurance and Governance

8.1 TSDFT Integrated Safeguarding and Inclusion Group (ISIG).

The Integrated Safeguarding and Inclusion Group is the executive-led forum responsible for oversight of safeguarding adults and children statutory functions and related themes, including exploitation, domestic abuse and sexual violence. During 2025/26, the group's assurance should be evidenced through its recorded consideration of key risks, decisions, escalations, outstanding actions and matters referred to executive or committee governance. Where this evidence is not yet available for the report, this remains an assurance gap requiring a named owner and completion date.

8.2 Adult Social Care Divisional Leadership Meeting (DLT)

DLT maintains Torbay Council oversight of the existing s75 arrangements including operational activity, emerging risks and overall practice assurance in adult social care including safeguarding systems and processes.

8.3 Adult Social Care Assurance Board (ASCIB)

Led by the Director of Adult Social Services (DASS), this Board was established in early 2026 and is supported by a lead officer from Torbay and South Devon NHS Foundation Trust (TSDFT). The purpose is to receive assurances relating to Care Act, MCA and wider statutory duties including professional practice information.

8.4 Quality Assurance Committee (QAC)

Reporting information from Adult Social Care Improvement Board is transferred by exception into the Adult Social Care QAC report.

8.5 Safeguarding Improvement Group (SIG)

While not a formal governance committee, the Safeguarding Adults Improvement Group (SIG) plays a vital role in supporting the quality assurance and continuous improvement of safeguarding adult practice across the system. The group provides a forum for safeguarding practitioners to collectively review how safeguarding arrangements and processes are operating, identify emerging themes, risks and practice issues, and agree actions to address areas requiring improvement. This directly supports the group's purpose of monitoring and providing assurance regarding the quality of safeguarding systems and practice.

The group also makes an important contribution to organisational learning by receiving and considering information from Safeguarding Adult Reviews (SARs), national guidance, policy developments and local partnership updates. Members analyse learning outcomes, identify implications for practice, and support the

dissemination of key messages and improvement actions across operational teams, helping to strengthen safeguarding practice and service delivery.

8.6 s75 Partnership Board

QPC will receive safeguarding assurance through clear exception reporting from the relevant Adult Social Care and Trust governance routes during the transition period. Each material risk will have a named executive owner, an accountable operational lead, an agreed reporting frequency and a defined escalation threshold. The transition plan will specify which organisation owns each statutory duty, control, dataset and improvement action before and after transfer, so that no gap in accountability or oversight arises as Adult Social Care responsibilities move to Torbay Council.

9.0 Other safeguarding activity

9.1 County Lines

This activity remains a significant safeguarding concern across Devon and Torbay with ongoing concerns for criminal exploitation of both adults and children. This includes coercion, intimidation, violence, debt bondage, and 'cuckooing', where vulnerable adults are exploited and their homes are used to facilitate criminal activity.

Local partners within TDSAP recognise the close relationship between County Lines, criminal exploitation, modern slavery, serious violence, missing episodes, and wider safeguarding concerns. Throughout 2025/26, agencies have continued to work collaboratively to raise awareness, strengthen intelligence sharing, identify individuals at risk, and support victims of exploitation.

TSDFT and Torbay Council have continued to contribute to local partnership arrangements and safeguarding responses relating to exploitation. However, attendance at some partnership meetings has been affected by workforce changes during the reporting period.

Through continued multi-agency collaboration, partners remain committed to identifying exploitation early, disrupting criminal activity, and improving outcomes for vulnerable adults and children within Torbay.

During 2026/27, representation across safeguarding partnership arrangements will be reviewed as part of the transition of Adult Social Care functions from TSDFT to Torbay Council, ensuring continued engagement in key safeguarding forums and effective contribution to the wider anti-slavery and exploitation agenda.

9.2 Sexual Safety in the Workplace

During 2025/26, TSDFT continued to support the NHS England Sexual Safety Charter and its commitment to a zero-tolerance approach to sexual harassment, abuse, and misconduct. The Trust remains committed to ensuring a safe environment for patients, staff, volunteers, learners, and visitors

During 2026/27, the Trust will strengthen implementation of the NHS England Sexual Safety Charter Assurance Framework through enhanced governance, policy review, workforce training, staff support arrangements, and organisational assurance processes to ensure concerns are identified, reported, and managed effectively.

9.3 Statement from NHS Devon Integrated Care Board (ICB)

NHS Devon ICB is a member of the Torbay and South Devon Safeguarding Adults Partnership. TSDFT and Torbay Council continue to work closely with the ICB on governance, strategic oversight and their shared commitment to safeguarding adults across the local system.

9.4 Ensuring quality of care in regulated care

The quality and safety of care provided within Torbay's care home sector is supported through a robust quality assurance and oversight framework. Responsibility for provider quality oversight sits with the TSDFT Markets, Contracts and Quality (MCQ) Team, with additional oversight provided through Adult Social Care Commissioning governance arrangements within Torbay Council.

The MCQ Team operates a Provider Quality Support Protocol (PQSP) and provides a structured and proportionate approach to monitoring provider performance and managing quality concerns. Using a four-tier escalation process this includes:

- **The collection and review of intelligence** from a range of sources, including incidents, complaints, safeguarding concerns, Care Quality Commission (CQC) inspection outcomes, contractual performance information, key performance indicators, and intelligence shared through regular Care Provider Quality Assurance Huddles.
- **The analysis of information** to develop a comprehensive understanding of provider performance, identify emerging risks, and determine the appropriate quality assurance tier within the Provider Quality Support Protocol.
- **The implementation of timely and proportionate interventions** to support continuous improvement and ensure that services meet regulatory, statutory, contractual, and quality standards.
- **Close partnership working** with providers to promote sustainable improvements in quality, safety, governance, and outcomes for people receiving care and support.

The Provider Quality Support Protocol continues to demonstrate its effectiveness in supporting provider oversight and driving quality improvement across the local care market. At the end of the reporting period, 96% of Torbay care home providers were

assessed as Business as Usual (BAU) or Tier 1, providing assurance that commissioned providers are delivering care that meets expected quality and safety standards. This reflects the ongoing commitment of both providers and partner organisations to maintaining high-quality, person-centred care for adults living within care home settings.

10.0 Summary

Overall, the evidence supports satisfactory assurance in several safeguarding domains, but not across the full control environment. Positive activity includes stronger partnership working, improved oversight of long-running Section 42 enquiries, completion of relevant Safeguarding Adults Review actions and strengthened training content. Material gaps remain in DoLS and Community DoL timeliness, Level 3 training compliance, demographic data completeness and the consistency of governance through transition. The overall assurance judgement therefore remains Limited until the report can demonstrate sustained delivery against agreed trajectories and evidence that the mitigations are reducing risk and improving outcomes.

The overall assurance rating may improve when there is sustained evidence that the DoLS and Community DoL backlogs are reducing in line with agreed trajectories; training compliance is recovering towards target; demographic data completeness has improved; governance evidence is available from all key oversight groups; and transition arrangements demonstrate clear ownership, reporting and escalation before and after transfer. Deterioration in these controls, missed milestones or evidence of harm or unlawful restriction should trigger exception reporting to QPC.

NHS
Torbay and South Devon
NHS Foundation Trust

Presented to:	Quality and People Committee			
Title of Report	Freedom to Speak up Service- Mid-Year Review			
Date of Meeting	27/10/26	**Author**	Kelly Ebdon-Marks, Deputy Director of People, People Experience	
Executive Lead	Jess Piper, Chief People Officer	**Executive Sign Off**	CPO	
Governance Route	People and Education Governance Group (PEGG)			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		x		
Executive Summary	This report provides a mid-year review of Freedom to Speak Up (FTSU) activity from April to September 2026 and offers assurance regarding the operation of the service, the nature of concerns being raised and the opportunities for organisational learning arising from those concerns. The review demonstrates continued engagement with the service across a broad range of professional groups and services. During the first six months of 2026/27, a total of 48 concerns were raised through the Freedom to Speak Up service, including seven anonymous concerns. The most common themes related to workplace culture and behaviours, staff wellbeing and psychological safety, organisational processes, and confidence in organisational responses. Concerns regarding perceived detriment, fairness and transparency also emerged as recurring themes, highlighting the importance of maintaining robust assurance arrangements and fostering an environment where colleagues feel safe to speak up. The review indicates that colleagues continue to view the service as an accessible and valued source of support and advice. Whilst concerns vary in nature and complexity, the majority relate to staff experience, workplace culture and organisational processes rather than isolated incidents. The intelligence generated through the service provides valuable insight into the lived experience of colleagues and complements wider workforce, wellbeing and culture information available to the Trust. The reporting period also marks an important development in the evolution of the Trust's speaking up arrangements. Following approval of the revised operating model, a new independent Freedom to Speak Up service launched on 12 October 2026. The service provides colleagues with access to externally employed Freedom to Speak Up Guardians and reflects the Trust's commitment to strengthening independence, accessibility and confidence in speaking up arrangements. Future			

Torbay and South Devon NHS Foundation Trust

	reporting will monitor service utilisation, emerging themes and the impact of the new model on staff confidence and organisational learning. Overall, the report provides assurance that colleagues continue to raise concerns and seek support when needed. It also identifies a number of priorities for the second half of the year, including embedding the new independent service, strengthening oversight of detriment concerns, improving feedback mechanisms and ensuring that learning from Freedom to Speak Up concerns continues to inform the Trust's culture, leadership and staff experience agenda.
Recommendation	The Committee is asked to receive the report, take **moderate assurance** from the arrangements in place to support Freedom to Speak Up across the Trust, note the implementation of the new independent Freedom to Speak Up service, and endorse the priorities identified for the remainder of 2026/27.

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 report supports delivery of the Caring, Skilled People Ready for Tomorrow strategic objective by providing assurance that colleagues have access to effective mechanisms to raise concerns, seek support and contribute to organisational learning. The report highlights themes relating to workplace culture, wellbeing, psychological safety and staff experience, and demonstrates how the new independent Freedom to Speak Up service will further support an open, inclusive and supportive working environment.

Board Assurance

BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
BAF-WF	People and culture	12	Supports C6: Staff engagement and staff voice

Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
					X

Compliance / Regulatory Requirements	Supports compliance with NHS Freedom to Speak Up requirements and National Guardian's Office expectations by providing oversight of speaking up activity, organisational learning and staff confidence in raising concerns.
Ethical or EDI implications?	Freedom to Speak Up supports an inclusive culture by providing a safe and confidential route for colleagues to raise concerns about workplace culture, behaviours, discrimination and staff experience. The new independent service aims to further strengthen accessibility, equity and confidence in speaking up.

Assurance rating	Significant	Moderate	Limited	Inadequate
		x		
Assurance rationale	The Committee can take moderate assurance that arrangements are in place to support colleagues to raise concerns and that themes, risks and learning are being identified and reported. The introduction of an independent Freedom to Speak Up service further strengthens these arrangements. However, ongoing themes relating to psychological safety, perceived detriment, workplace behaviours and confidence in organisational responses mean continued monitoring and improvement are required.			
Appendices				

Freedom to Speak Up Service Mid-Year Review

April - September 2026

1. Purpose

This report provides a mid-year review of Freedom to Speak Up (FTSU) activity between April and September 2026. The report aims to provide assurance regarding service utilisation, highlight emerging themes and risks, and identify opportunities for organisational learning and improvement.

2. Introduction

Freedom to Speak Up forms a key component of the Trust's approach to fostering an open, inclusive and psychologically safe culture in which colleagues feel able to raise concerns, seek advice and challenge poor practice without fear of disadvantage or detriment. The service provides an independent and confidential route for staff to discuss concerns relating to patient safety, quality of care, workforce experience, workplace culture and organisational processes.

This report provides a summary of Freedom to Speak Up activity between April and September 2026 and is intended to provide assurance regarding the operation of the service, the nature of concerns being raised and the key themes emerging across the organisation. The report draws upon data contained within the Quarter 1 Freedom to Speak Up report, alongside cases managed through the Freedom to Speak Up service during Quarter 2.

The report highlights activity levels, emerging themes, organisational learning and areas requiring continued focus, supporting the Trust's commitment to strengthening staff experience, promoting a just and learning culture and ensuring concerns raised by colleagues contribute to organisational improvement

The report largely reflects activity under the previous FTSU arrangements, and therefore establishes a baseline against which the impact of the new independent service can be assessed during 2026/27.

3. Activity Summary

The volume and nature of concerns raised during the first half of 2026/27 indicate that colleagues continue to view the Freedom to Speak Up service as an accessible route for support and advice. Whilst concerns relating to culture, behaviours, organisational processes and psychological safety remained the most common themes, the breadth of issues raised demonstrates the important role the service plays in providing independent support and identifying opportunities for organisational learning and improvement.

The service received a total of 48 concerns during the first half of the year, of which 7 were raised anonymously. Feedback received during the period suggests that whilst staff continue to utilise the service, ongoing attention is required to strengthen confidence in organisational responses, transparency and protection from detriment after speaking up.

3.1 Activity Overview

Measure	April - September 2026
Total concerns raised	48
Anonymous concerns	7
Feedback responses received	15
Concerns relating to detriment	Significant recurring theme
Most common themes	Culture, behaviours, wellbeing, organisational processes

Figures include information from the Quarter 1 FTSU report and concerns managed through the service during Quarter 2.

Whilst activity volumes provide an indication of utilisation, the themes arising from concerns provide the most valuable insight into staff experience, organisational culture and areas requiring improvement.

4. Key Themes

Theme	Examples of Concerns Raised
Workplace culture and behaviours	Bullying, harassment, inappropriate behaviours, relationship breakdowns and management interactions
Staff wellbeing and psychological safety	Wellbeing concerns, feelings of vulnerability, perceived detriment and confidence to speak up

Organisational processes	Grievances, disciplinary processes, sickness management, complaints handling and job evaluation processes
Patient safety and quality concerns	Concerns relating to service delivery, staffing levels and patient care
Organisational learning and accountability	Concerns regarding fairness, transparency and confidence in organisational responses

4.1 Overall Themes and Learning

A consistent picture emerges across the first half of 2026/27. Most concerns relate to staff experience, workplace culture and organisational processes rather than isolated incidents. Concerns frequently reflect how colleagues experience behaviours, leadership responses, organisational decision-making and psychological safety within their working environment. This provides the Cultural Insights Review Group (CIRG) with valuable intelligence to ensure appropriate interventions are prioritised.

Whilst concerns continue to vary in nature and complexity, the themes identified provide valuable intelligence to support culture improvement, workforce wellbeing and organisational learning. The findings are broadly consistent with intelligence gathered through wider staff experience, wellbeing and culture initiatives across the Trust.

5. Professional Groups Engaging with the Service

The Quarter 1 report identified registered nurses and midwives, administrative and clerical staff and additional clinical services as the professional groups most frequently associated with Freedom to Speak Up concerns. Professional group analysis is intended to identify where concerns are experienced rather than to count individual cases, as concerns may involve multiple professional groups.

In Quarter 2, concerns continued to be raised by colleagues across a broad range of clinical and non-clinical services, including nursing, administrative and clerical staff, allied health professionals, medical staff, estates and facilities teams, managers and social care colleagues.

The breadth of professional groups engaging with the service suggests that the Freedom to Speak Up service remains visible and accessible across the organisation and is not associated with a single staff group, profession or service area. This supports confidence that the service is reaching a broad cross-section of colleagues.

6. Freedom to Speak Up Service Development

Following approval of the revised Freedom to Speak Up model, the Trust launched a new independent Freedom to Speak Up service on 12 October 2026. The new service replaces the previous Work in Confidence arrangements and provides colleagues with access to

externally employed Freedom to Speak Up Guardians who are independent of the Trust. This development reflects the Trust's commitment to strengthening staff confidence in speaking up and responding to feedback from colleagues who indicated they would value access to a service that sits outside local management and organisational structures.

The new service provides:

- Independent and confidential support from externally employed Freedom to Speak Up Guardians.
- An additional route for raising concerns outside normal management channels.
- Telephone, online and face-to-face support.
- The opportunity for colleagues to discuss concerns and receive advice before deciding on any formal action.
- Ongoing guidance and support throughout the speaking up process.

The new arrangements are intended to further strengthen psychological safety, increase confidence in speaking up and support the Trust's ambition to create an open, inclusive and learning culture where concerns can be raised safely and addressed appropriately.

The Committee will receive future reports on service activity, emerging themes and organisational learning from the new arrangements as they become established.

7. Organisational Insights

The themes identified through Freedom to Speak Up cases provide valuable insight into staff experience across the Trust.

7.1 Psychological Safety

Many concerns raised relate to individuals feeling vulnerable, unsupported or uncertain about challenging issues within their workplace. Concerns relating to wellbeing, detriment and workplace relationships suggest psychological safety remains a key organisational priority.

7.2 Processes and Fairness

Staff continue to seek support regarding organisational processes including grievances, disciplinary matters, complaints management, sickness processes and job evaluation procedures. This suggests opportunities to strengthen understanding, consistency and communication regarding organisational procedures.

7.3 Behaviour and Culture

Bullying, harassment, inappropriate behaviours and concerns regarding management responses continue to feature prominently. The persistence of these themes demonstrates the importance of linking FTSU intelligence with broader leadership, culture and behavioural improvement programmes.

7.4 Confidence Following Speaking Up

The number of anonymous concerns raised, together with feedback regarding detriment and fairness, highlights the importance of ensuring staff feel protected and supported after raising concerns.

8. Risk and Areas for Assurance

Whilst no immediate systemic patient safety concerns have emerged through the reporting period, the themes identified highlight several areas requiring continued organisational attention and assurance. The themes from Q2 further support the organisations focus on priorities such as the Learning and Culture Roadshows, behaviours framework, and leadership and management development.

The key risks identified through the mid-year review are set out below. The implementation of the new independent Freedom to Speak Up service provides an opportunity to strengthen assurance in a number of these areas; however, ongoing monitoring will be required to assess the impact of the new arrangements on staff confidence, accessibility and organisational learning.

Risk Area	Assurance Consideration
Perceived detriment after speaking up	Strengthen oversight, escalation arrangements and monitoring through the new independent service
Confidence in organisational responses	Improve feedback and closure processes and evaluate the impact of the new service model
Bullying, harassment and behaviours	Continued scrutiny through culture and leadership programmes
Psychological safety and wellbeing	Strengthen support mechanisms and early intervention
Visibility of organisational learning	Demonstrate actions taken in response to concerns and lessons identified through FTSU reporting

There has been one complaint from a user regarding the FTSU service experience and response received. This is currently being investigated and outcome and recommendations due w/c 2nd November for review by the CPO and lead FTSU NED.

9. Priorities for October 2026 - March 2027

a) Embed the new independent Freedom to Speak Up service and associated governance arrangements.
b) Monitor service utilisation, accessibility and staff feedback following implementation of the new model.

c) Strengthen assurance processes relating to detriment concerns.
d) Improve feedback and communication with individuals raising concerns.
e) Ensure recurring themes inform wider culture, leadership and staff experience programmes.
f) Develop integrated reporting that links FTSU intelligence with workforce, patient safety and staff survey findings.
g) Maintain visibility and oversight of concerns relating to behavioural standards, discrimination, harassment and workplace culture.
h) Review emerging themes and outcomes from the new service arrangements to support continuous improvement and organisational learning.

10. Conclusion

Freedom to Speak Up activity during the first half of 2026/27 demonstrates that colleagues continue to use the service to seek support, raise concerns and access independent advice. The service provides valuable organisational intelligence regarding staff experience, culture, wellbeing and confidence in organisational processes. Whilst colleagues continue to speak up and utilise the service, themes relating to psychological safety, detriment, fairness and organisational response indicate further work is required to strengthen confidence in what happens after concerns are raised.

The introduction of the new independent Freedom to Speak Up service in October 2026 represents a significant development and reflects the Trust's continued commitment to ensuring colleagues have access to a confidential, independent and accessible route for raising concerns. Future reporting will help assess the impact of the new arrangements on staff confidence, service utilisation and organisational learning, whilst ensuring concerns raised by colleagues continue to inform improvements in both staff experience and patient safety.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Quality and People Committee**			
Title of Report	Cultural Insights Review Group (CIRG): Organisational change, focussed team support and culture assurance report			
Date of Meeting	**27.10.26**		**Author**	Laura Fuller, Deputy Director of People, People Development
Executive Lead	**Jess Piper, Chief People Officer**		**Executive Sign Off**	CPO
Governance Route	Cultural Insights Review Group (CIRG) People and Education Governance Group (PEGG)			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
		X	X	
Executive Summary	**Assurance position: Limited assurance,** with an improving direction of travel. The principal risks are the cumulative impact of 18 organisational change programmes affecting approximately 1,100 staff, the transfer of more than 300 adult social care colleagues, sustained sickness absence, behaviour and conduct concerns, and variable local ownership of improvement actions. **Progress and strengthened controls:** Organisational change, sickness absence, and behaviour and conduct are now standing CIRG agenda items, enabling sustained oversight, earlier identification of deterioration and clearer challenge. Focused support is monitored through jointly owned action plans, with one team reporting improved wellbeing, stronger supervision and greater engagement with Trust-wide support. **Outstanding gaps:** People and Education capacity is limited while the restructure is completed. Information is incomplete for some services, and mediation capacity remains uncertain pending a proposal for the future model. These gaps may affect the speed of support and confidence that risks are reducing. Work is progressing on the sickness absence deep dive, Behaviour Framework monitoring and culture dashboard.			
Recommendation	QPC is asked to note that limited assurance remains appropriate and that the direction of travel is improving; note progress in strengthening oversight and focused support; support resolution of capacity or organisational barriers that delay agreed action; and receive a further update showing the current position, evidence of impact, named leads and review points for organisational change, sickness absence, behaviour and conduct, focused team support and the culture dashboard.			

Torbay and South Devon NHS Foundation Trust

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 paper supports a skilled, engaged and sustainable workforce by strengthening cultural intelligence, leadership accountability, early intervention and coordinated support during organisational change.					

Board Assurance			
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
BAF-WF	People and culture	12	Provides assurance that staff experience and culture are overseen, monitored and actions are put in place to address areas of concern. Supports C1, C3, C5, C6 key controls.

Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
	X	X	X	X	X

Compliance / Regulatory Requirements	The work supports effective workforce governance, staff experience, equality and inclusion, Freedom to Speak Up, safe organisational change and well-led oversight.			
Ethical or EDI implications?	There are positive EDI implications through improved triangulation of staff experience, inclusion, behaviour and workforce intelligence. Interventions must remain fair, evidence-based, confidential and accessible, with attention to differential staff experiences during change.			
Assurance rating	Significant	Moderate	Limited	Inadequate
			X	
Assurance rationale	Significant workforce and cultural risks remain active; evidence that actions are improving staff experience is not yet consistent; information is incomplete for some services; and current People and Education and mediation capacity may affect delivery. Oversight and focused support have strengthened, giving an improving direction of travel.			
Appendices	**Appendix 1: CIRG Action Plan**			

1. Purpose

This paper provides QPC with an assurance update on the workforce and cultural intelligence considered by CIRG in the most recent reporting month. It sets out the current assurance judgement, evidence of progress since the previous reports, outstanding control and capacity gaps, agreed interventions, and the matters requiring escalation or continued oversight.

Principal areas are the cumulative impact of organisational change, sustained sickness absence, behaviour and conduct, focused support for teams and services, and development of an integrated organisational culture framework.

CIRG's role is to triangulate workforce data, staff feedback, employee relations, Freedom to Speak Up, incident intelligence, inclusion and organisational development information; coordinate proportionate support; and provide challenge and escalation where local action is insufficient.

2. Organisational change and workforce impact

CIRG continues to oversee the workforce and cultural impact of 18 organisational change programmes affecting around 1,100 staff, alongside the transfer of more than 300 adult social care colleagues. The scale and timing of this work may place additional pressure on staff and managers and may affect sickness absence, staff experience and the ability of teams to respond to other concerns.

Organisational change is now a standing item at CIRG. This allows the group to look at information from different sources, identify themes earlier and check whether appropriate support is in place. Assurance remains limited because the effect of the changes is still developing and evidence that risks are reducing is not yet consistent.

3. Sickness absence

Sickness absence is now a standing CIRG item. A deep dive is being carried out to identify the main causes, patterns and areas of concern – the outcome report is coming to QPC in November. The findings will be reviewed by CIRG and used to set priorities for services and inform the Trust wellbeing plan and its measures of success. Workforce data and local information will also help identify where absence may relate to workload, wellbeing, leadership or team culture. Where concerns are identified, CIRG will check that the service has a clear response and access to appropriate People and wellbeing support via HRBPs.

Progress will be shown through clear service actions, named leads, agreed completion dates and evidence that absence levels or the reasons behind them are being addressed. CIRG will raise concerns with QPC where support cannot be provided, actions are repeatedly delayed or the position worsens.

4. Behaviour and conduct

Behaviour and conduct concerns are being reviewed alongside employee relations, Freedom to Speak Up, incident, inclusion and staff feedback information. This gives CIRG a fuller picture and helps the group distinguish between an individual issue and a wider team or service concern.

Where themes are identified, the service will be expected to agree action and show whether it has improved staff experience or reduced the concern. The launch of the

Behaviour Framework will also be monitored to understand its impact, identify where further support is needed and shape future action. CIRG will continue to review progress and will bring the issue to QPC if local action is not happening or is not making enough difference.

5. Focused support for teams and services

Focused support has been agreed for teams identified through workforce data and local intelligence. Services remain responsible for their own improvement actions, with CIRG bringing together advice and support where this will help. Progress continues to be reviewed through jointly owned action plans.

Each action plan records the concern, agreed action, responsible lead, review point and how improvement will be measured. This enables CIRG to review whether support has made a difference, rather than only whether activity has taken place.

Impact example: for one team identified as at risk via CIRG in ealry 2026, focused support has included a leadership 360 review, followed by action to improve the quality and consistency of supervision. The team is engaging more with Trust-wide support such as preceptorship and staff networks, helping to reduce silo working and strengthen links with the wider organisation. The team has reported improved staff wellbeing. Sickness absence data will be reviewed at the agreed review points to confirm whether this is also reflected in workforce measures.

Appendix 1 is an anonymised CIRG action log.

6. Progress and impact

Progress made: CIRG is reviewing key risks regularly; information from different sources is being considered holistically; concerns are being identified earlier; focused team support has been agreed and delivered; and responsibility for local action is clearer.

Measuring culture change over time: CIRG reviews a range of data that provides different indicators of staff experience and organisational culture. Future reports will present available trends over time and identify where the data shows improvement, no change or deterioration. At this stage, the information does not provide a single measure of Trust-wide culture change or show how long change will take.

Culture dashboard: development of the culture dashboard is continuing and has progressed since it was raised at the previous reporting point. The dashboard will bring together clear datasets for regular review and support more consistent reporting of trends across the Trust.

Area and lead	Current position and control	Evidence available	Impact and next assurance point
Organisational change	Standing oversight of 18 programmes	Workforce trends, staff feedback,	Oversight has strengthened, but

CIRG oversight; service and programme leads own local action. Deputy Director of People, People Experience	affecting around 1,100 staff and the transfer of more than 300 colleagues.	local intelligence and delivery of agreed support actions.	consistent evidence that workforce and cultural risks are reducing is not yet available. The next update will report the direction of relevant workforce trends and progress against agreed actions.
Sickness absence and wellbeing CIRG oversight; service leads own local action. Deputy Director of People, People Experience	Sickness absence is a standing item and a deep dive is underway. Findings will inform service priorities and the Trust wellbeing plan.	Sickness absence data, reasons for absence, local intelligence, service actions and wellbeing measures.	The deep dive will identify themes and priority actions. The next update will report the themes, agreed actions, leads, review points and any early change in sickness absence or wellbeing measures.
Behaviour and conduct CIRG oversight; service and People leads support delivery. Deputy Director of People, People Development	Behaviour concerns are reviewed alongside employee relations, Freedom to Speak Up, incident, inclusion and staff feedback information. The Behaviour Framework launch includes development sessions, manager guidance and practical support.	Attendance and reach, staff and manager feedback, confidence in using the framework, use in supervision and team discussions, requests for support, behaviour concerns and staff experience data.	The next update will show whether the framework is reaching staff, being used in practice and identifying where further development or support is needed.

Focused team support Service lead owns the action plan; CIRG coordinates support and review. Head of People Experience and Business Partnering and HRBPs	Joint action plans and links to Trust-wide support are in place. For one team, support included a leadership 360 review and action to improve supervision.	The team has reported improved wellbeing, stronger supervision and greater engagement with Trust-wide support.	Sickness absence, staff feedback and action-plan progress will be reviewed at agreed points to confirm whether improvements are sustained and reflected in workforce measures.
Culture dashboard CIRG oversees development and use. Deputy Director of People, People Development	Development has progressed since the previous update. Datasets are being brought together to support regular review and identify areas requiring attention.	Existing workforce, staff experience, behaviour, Freedom to Speak Up and incident datasets.	The dashboard will provide a consistent set of measures for reviewing trends across the Trust. The next update will confirm the datasets included, reporting arrangements and the first available trend view.

Further action: impact evidence is not yet consistent across services, staff survey action-plan engagement varies, and information remains incomplete in some areas. Current People and Education and mediation capacity may also affect how quickly support can be provided. These issues will remain under review while the People and Education organisational change is completed, with any effect on delivery reported to QPC.

7. Action and milestone delivery assurance

This table provides update of action to delivery, evidence of impact and escalation. Status is updated at each CIRG review using Green (on track), Amber (at risk or evidence incomplete) or Red (off track or requiring escalation).

Priority and accountable lead	Action and milestone	Target / review point	Status and evidence required
Organisational change CIRG oversight;	Review workforce and cultural impacts across	At each CIRG meeting;	**Amber.** Evidence: relevant workforce

service and programme leads accountable.	all active change programmes; confirm that each programme has proportionate staff support and an escalation route.	consolidated position in the next QPC update.	trends, staff feedback, delivery of support actions and exceptions requiring escalation.
Sickness absence and wellbeing CIRG oversight; service leads accountable.	Complete the deep dive, identify priority themes and agree service actions, named leads and measures linked to the Trust wellbeing plan.	Findings and action plan for the next assurance update.	**Amber.** Evidence: deep-dive findings, action owners, completion dates, absence trends and wellbeing measures.
Behaviour and conduct Service and People leads accountable.	Monitor the reach and practical use of the Behaviour Framework and identify where further development or support is required.	Review at each CIRG meeting; report initial reach and use in the next QPC update.	**Amber.** Evidence: attendance, staff and manager feedback, use in supervision and team discussions, support requests and relevant concern trends.
Focused team support Service lead owns each action plan; CIRG coordinates support.	Maintain jointly owned action plans and review whether interventions are improving staff experience and workforce outcomes.	At each agreed action-plan review point; exceptions escalated promptly.	**Amber.** Evidence: action completion, staff feedback, supervision quality, engagement with support and sickness absence trends.
Culture dashboard CIRG oversees development and use.	Confirm the core datasets, reporting arrangements and first trend view to support consistent Trust-wide cultural assurance.	Dataset and reporting design confirmed for the next assurance update.	**Amber.** Evidence: agreed dataset, reporting cycle, data-quality position and first available trend view.

Escalation threshold: a priority or escalation will be brought to QPC where delivery is delayed, evidence remains incomplete, the accountable lead cannot secure required support, or available measures indicate deterioration.

8. Risks

Residual risk	Current control and oversight
Limited People and Education capacity may delay support.	Capacity is reviewed through CIRG and raised with QPC where it affects delivery.
Incomplete information may prevent a clear view of risk in some services.	CIRG brings together workforce data, staff feedback and local intelligence and requests further information where needed.
Local actions may not be completed or may not improve staff experience.	Joint action plans record the concern, action, lead, timescale and measure of improvement.
Trust-wide cultural impact is not yet consistently measurable.	Development of the culture dashboard is continuing, alongside trend reporting from existing datasets.
Mediation capacity remains uncertain.	The position is monitored and will be raised with QPC if it prevents timely support.

9. Recommendation

QPC is asked to note that **limited assurance** remains appropriate and that the direction of travel is improving.

QPC is asked to note the strengthened controls and early evidence of impact, including regular review of key risks, focused team support, reported improvement in one team, and progress on the sickness absence deep dive, Behaviour Framework monitoring and culture dashboard.

QPC is asked to support resolution where capacity or organisational barriers are delaying agreed action and to receive a further update showing, for each priority area, the current position, evidence source, responsible lead, review point and measurable change. CIRG will bring matters back to QPC where agreed action is delayed, support cannot be provided or the level of concern increases.

10. Conclusion

Limited assurance remains appropriate, with an improving direction of travel. CIRG has strengthened oversight, introduced clearer action planning and coordinated focused support. One team has reported improved wellbeing, stronger supervision and greater engagement with Trust-wide support. Work is also progressing on the sickness absence deep dive, monitoring the Behaviour Framework launch and developing the culture dashboard. Assurance cannot yet

improve because measurable impact is not available
consistently across services, some information remains incomplete and current capacity may affect delivery. The next report will show the current position, evidence source, named lead, review point and measurable change for each priority area.

Torbay and South Devon NHS Foundation Trust

Appendix 1: CIRG Action Log

This appendix provides an anonymised overview of CIRG actions, recorded assurance positions, next steps, timing and status.

CIRG Action Overview

source action logs and subsequent recorded contacts | No personal names or case-level details | Latest recorded update: Oct 2026

36	23	6	2
Assurance records	Active or ongoing	Completed	Paused

Care Group	First contact	Latest update	Anonymised action / support	Assurance position	Next action / review	Timing	Status
	21 Nov 2025	21 Nov 2025	Offered ongoing listening opportunities and multidisciplinary clinical supervision.	Invitations and support offer were completed.	Monitor uptake through existing education routes.	Completed	Completed
	21 Nov 2025	05 May 2026	Co-designed a team support action plan and arranged a follow-up meeting.	Action plan agreed; latest log awaited the end-of-May review.	Record the review outcome and any remaining actions.	End May / June 2026	Open
	21 Nov 2025	05 May 2026	Provided staff support, listening sessions and workforce data review.	Listening sessions completed and actions routed for follow-up.	Retain thematic learning through governance reporting.	Completed	Completed
	21 Nov 2025	05 May 2026	Repeated listening activity and reviewed embedding of the previous action plan.	Follow-up contact occurred and feedback was reviewed.	Maintain local check-ins and governance oversight.	Completed / monitor	Completed

	21 Nov 2025	13 Jul 2026	Develop and publish inclusive language guidance and supporting communications.	Guidance completed; publication and accessible distribution remain outstanding.	Confirm publication and reinforce through care groups and HR business partners.	Aug 2026 / ongoing	Open
	26 Nov 2025	17 Dec 2025	Co-designed the Enhanced Care for Staff approach and governance route.	Need for a structured support offer was established and process mapping progressed.	Maintain assurance through the wider programme review.	Programme cycle	Ongoing
	26 Nov 2025	01 Aug 2026	Considered staff support, workforce fragility and incident intelligence through patient-safety and governance routes.	Escalation and further trend analysis were commissioned.	Complete incident trend analysis and maintain governance oversight.	Aug-26	In progress
	04 Dec 2025	13 Jul 2026	Enhanced Care for Staff pilot, baseline surveys, stress assessment, stay conversations and service improvement support.	Baseline work completed; further intervention requires an agreed scope.	Confirm additional intervention and document outcomes.	Next governance review	In progress
	11 Dec 2025	11 Dec 2025	Request received for support with	Support need was identified; no later	Confirm whether intervention	To be confirmed	Open

		team working relationships.	outcome is recorded.	commenced and record outcomes.		
11 Dec 2025	11 Dec 2025	Healthy and Effective Teams intervention.	The source log records the issues as resolved.	Monitor through routine leadership channels.	Completed / monitor	Completed
11 Dec 2025	11 Dec 2025	Exploratory pre-contracting and senior-level discussions.	High-level conversations were still required.	Confirm scope, ownership and next decision.	To be agreed	Open
11 Dec 2025	11 Dec 2025	Healthy and Effective Teams assessment was considered.	Assessment was cancelled because of capacity.	Reassess need and capacity before restarting.	No date recorded	Paused
11 Dec 2025	11 Dec 2025	Brief Healthy and Effective Teams intervention.	The source log records the immediate issue as resolved.	Monitor through local leadership routes.	Completed / monitor	Completed
11 Dec 2025	11 Dec 2025	Brief Healthy and Effective Teams intervention.	Work was not completed after local engagement ended.	Confirm appetite, ownership and safe route to re-engage.	No date recorded	Paused
11 Dec 2025	11 Dec 2025	Raised a potential need to review team configuration and service design.	Need was identified but no completed review is recorded.	Decide whether a formal team-design review is required.	To be agreed	Open
17 Dec 2025	01 Aug 2026	Reviewed intervention prioritisation and introduced regular	Triage and standing reporting actions are recorded; monthly	Issue the monthly flash report and intervention update.	Monthly	Ongoing

			reporting on team-support activity.	reporting is expected.			
	27 Jan 2026	27 Jan 2026	Developed a feedback route for recurring leadership-behaviour themes.	Engagement and feedback mechanism were agreed.	Track delivery through existing governance.	Completed / monitor	Completed
	27 Jan 2026	13 Jul 2026	Supported survey interpretation, team development, leadership support and workforce pipeline work.	Multi-part intervention remains active; further formal improvement planning was proposed.	Agree a formal improvement plan and review leadership programme participation.	Aug-Oct 2026	In progress
	02 Feb 2026	02 Feb 2026	Service-development support linked to the Patient Access programme.	Active working relationship was recorded; no later outcome is stated.	Capture improvement outputs and next steps.	Programme cycle	Ongoing
	12 Feb 2026	13 Jul 2026	Used leadership routes to reinforce language guidance and organisational learning.	Reinforcement is recorded as an ongoing requirement.	Evidence dissemination and local follow-through.	Ongoing	Ongoing
	13 Mar 2026	14 Apr 2026	Explored reflective/restorative supervision, education and practical support tools.	Need and potential tools were discussed; follow-up coordination remained open.	Agree the supervision and education offer for priority areas.	Next programme review	Open

	23 Apr 2026	01 May 2026	Reviewed workforce safety intelligence, reporting themes and policy communications.	Two-year analysis and awareness activity were being developed; regular contact was planned.	Receive the analysis and monitor actions through monthly review.	Monthly from Jun 2026	Ongoing
	23 Apr 2026	01 Aug 2026	Linked incident and complaints intelligence to staff-support work and reviewed discrimination categories.	Categories and subcategories were updated; trend review continues.	Monitor data quality and report emerging themes.	Ongoing	Ongoing
	05 May 2026	05 May 2026	Requested action-plan assurance from care group leadership and executive governance.	Executive presentation is recorded as complete; detailed care group update remained planned.	Capture action-plan updates and assurance evidence.	Aug-26	Planned
	05 May 2026	05 May 2026	Started design of a champion approach for speaking-up and wellbeing support.	Baseline design requirements were identified but no completed model is recorded.	Define the baseline, role and implementation model.	To be agreed	Open
	05 May 2026	08 Jun 2026	Sought targeted input on information governance	Attendance and audit input were planned; the log does not	Confirm audit lead input and resulting actions.	Next CIRG review	Planned

			risk and audit intelligence.	record completion.			
	05 May 2026	08 Jun 2026	Requested review of incident, staff survey and employee-relations intelligence.	Comparative dataset review remained in progress.	Compare the latest dataset with the February baseline.	Next data review	In progress
	05 May 2026	08 Jun 2026	Sought external system benchmarking and intelligence.	Link to the wider system context remained open.	Bring benchmark findings into the next assurance review.	Next CIRG review	Open
	05 May 2026	12 Aug 2026	Reviewed risk ownership, incident trends and targeted support for higher-risk teams.	Oversight ownership recorded; trend monitoring and education actions continue.	Maintain risk review and reinforce requirements through development programmes.	Aug-Sep 2026	Ongoing
	05 May 2026	12 Aug 2026	Planned reinforcement of information governance through induction and leadership development.	Education action is scheduled rather than evidenced as complete.	Embed the agreed content and report delivery.	Sep-26	Planned
	01 Jul 2026	01 Jul 2026	Prepared workforce intelligence for governance sharing.	A reporting action is recorded; completion is not evidenced in the log.	Share the intelligence report through governance channels.	Jul-Aug 2026	Planned
	01 Aug 2026	01 Aug 2026	Proposed wider organisational use of	Opportunity identified; no	Develop an adoption proposal	Future meeting	Planned

		positive-learning mechanisms.	implementation evidence is recorded.	for a future meeting.		
	01 Aug 2026	01 Aug 2026	Requested review of organisational response to disability discrimination themes and adjustment practice.	Review is recorded as ongoing without a completion date.	Report findings, controls and improvement actions.	Ongoing	Open
	Sep 2026	Oct 2026	Contact received from the HRBP regarding workforce & team support.	Initial contact recorded; scope, required support and assurance evidence are to be confirmed in collaboration with ADNPP & Matron	Agree the support requirement, owner and review route.	Sep 2026 / next review	Open
	Sep 2026	Oct 2026	Contact received from ADNPP regarding team support.	Initial contact recorded; scope, required support and assurance evidence are to be confirmed.	Agreed the support requirement, owner and review route.	Sep 2026 / next review	Open
	Sep 2026	Oct 2026	Contact received from COO regarding workforce & team support.	Initial contact recorded; scope, required support	Agreed scope, further conversation with COO/CPO	Sep 2026 / next review	Open

and assurance evidence are to be confirmed.	to identify clear action plan in conjunction with work that is ongoing	