Torbay and South Devon
NHS Foundation Trust

Council of Governors Meeting

Public

Date: Wednesday 11 November 2026

Time: 2.00 pm – 3.45 pm

Venue: Microsoft Teams only

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Public Council of Governors

Board Room / Microsoft Teams

Torbay and South Devon NHS Foundation Trust

11/11/2026 14:00 - 15:45

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NHS
Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE PUBLIC COG MEETING
HELD AT 2 PM ON WEDNESDAY 12 AUGUST 2026
BOARD ROOM, TORBAY HOSPITAL AND VIA MS TEAMS

Governors Present:			
Olivia Bath	OB	Mike Blakley	MBl
Dave Cawley	DC	Loveday Densham	LD
Eileen Engelmann	EE	Mike Joyce	MJ
Richard Keeling	RK	Alison Meadows	AM
John Nutley	JN	Jake O'Donovan	JOD
Maroria Oroko	MO	James Osben	JO
Vicki Payne-Cater	VPC	Julie Spinks	JS
Andrew Stilliard	AS	Vincent Williams	VW
Louise Winfield	LW	Radia Woodbridge	RW
Ged Yardy	GY		

Directors Present:		
Martin Beaman	Chair	MBe
Mark Greaves	Non-Executive Director	MG
Paul Richards	Senior Independent Director/Non-Executive Director	PR
Joe Teape	Chief Executive	JT
Kate Lissett	Chief Medical Officer	KL
Nicola McMinn	Chief Nurse	NM
Jane Harris	Director of Communications	JH

In Attendance:		
Sarah Fox	Corporate Governance Manager	SF
Cath Parnell	Chief of Staff	CP
Jean Thomas	Member of the Public	JT

1.	**OPENING MATTERS**
1.1	**Chair's welcome and apologies** The Chair welcomed those present to the Council of Governors meeting. Apologies for absence were received from the following Governors: Karen Barry, Joanna Bowtell and Andrew Postlethwaite. Apologies were also received from: Jess Piper, Chief People Officer, Chris Saxby, Non-Executive Director and Simon Tapley, Chief Strategy and Planning Officer.
1.2	**Declarations of Interest** No declarations of interest were received.

2.	**BUSINESS FROM PREVIOUS COUNCIL OF GOVERNORS MEETINGS**
2.1	**Minutes of the meetings held on 13 May 2026** The Council of Governors approved the minutes of the Council of Governors' meeting held on 13 May 2026, with one amendment – page 2 of the minutes referred to 'Royal Devon University Hospital' when it should read 'Royal Devon University Healthcare' *(post meeting note – actioned)* The action log was reviewed and updates received on outstanding actions.
2.2	**Matters arising not covered elsewhere on the agenda** There were no matters arising.
3.	**BUSINESS REPORTS**
3.1	**Chair's Report** The Chair reported the following: • The Trust had recently appointed two new consultant histopathologists. • MBe reflected on current social media posts stating potential applicants may not choose to apply for posts at the Trust due to negative social media. It was suggested the Trust could promote a good news story around the appointment of the histopathologists. It was noted that the Trust would first need to ensure the two successful candidates were happy to be part of a good news story. • The CoG discussed a view that the Trust did not promote good new stories on a regular basis, noting the difficulties in correcting misinformation that was circulated through social media and other channels, and how it was difficult as a Governor when being challenged by constituents if they did not have a full understanding of the issues being managed by the Trust. • JT informed the CoG that the Trust's website provided direct links with accurate information to counter misinformation that was being circulated on social media etc. He added that there was a balance between celebrating successes when it was well understood the lived experiences for some staff at the Trust was currently very difficult due to levels of demand and low morale. It is a difficult balance to manage. • It was suggested it would be helpful to understand the current number of vacant consultant posts and the length of time they had been vacant. **Action: JT** • It was noted that some consultant posts were more difficult to recruit to than others, for example in respect of Urology the Trust did not undertake any major cancer work or used robots in that specialty, making it less attractive than positions at other Trusts. • Some services were considered fragile, for example Neurology, and in services that were single handed or fragile, work was currently taking place to consider alternative models of delivery both to support small numbers of staff currently trying to deliver a service and to ensure patients received the best level of care possible. • It was agreed the current Governor briefing would be reviewed to ascertain if additional information could be provided to ensure Governors were properly briefed on areas of interest, for example consultant recruitment. **Action: JT/JH** • As well as consultant histopathologist appointments, consultant appointments had been made in Oncology, Emergency Department; Obstetrics and Trauma and Orthopaedics (hand surgeon).

	• AS asked if there would be an impact to the Trust given North Devon had temporarily closed its maternity unit. NM explained that Region had asked Trusts in the system to undertake a risk assessment due to the closure. She added that there was not expected to be an immediate impact. The Royal Devon University Healthcare (RDUH) Trust might ask the Trust to support some elective work, however this was a process that had been in place for some time as the Trust had supported the RDUH in the past when it was in escalation as part of mutual aid arrangements. • The CoG noted that, since the last meeting, MBe had undertaken visits to Oncology and Linear accelerators. He had also recently visited Castle Circus Health Centre, with Ali Meadows, to meet the Podiatry team. As well as podiatry, the Health Centre also provided dentistry, sexual health and speech and language services. It was noted that Mark Greaves had also undertaken a visit to the Harbour Unit with Eileen Englemann. • MBe had recently met with the Trust's Director of Capital Estates to understand the Trust's vision for the development of its estate. He had also learnt about the work of a member of staff who worked with private commercial developers planning housing developments of 50 houses or more, to negotiate funding from the developers to support health services and infrastructure for the new population who would live in those houses. • Several Governors (Dave Cawley, Mike Joyce and Andrew Stilliard) were interested in understanding more about this work. **Action: SF** *(post meeting note – actioned)*
3.2	**Lead Governor Update** The Lead Governor reported the following: • Since the last meeting the Trust had appointed three new Non-Executive Directors. • Governor elections were currently underway to appoint governors to vacant positions • The number of questions Governors were dealing with from members of the public due to misinformation being shared by the Save Torbay Hospital campaign. • NED involvement with Governors had started to expand with NEDs attending CoG Priorities meetings and Governors joining NEDs when they visited different areas of the Trust. In addition the 15 Steps Safety Walkarounds would be recommencing in the near future. An invitation was extended to NEDs to join any of the CoG Constituency meetings if they wished. • LD raised concern around the length of waiting lists and asked if Governors could receive information that detailed the waiting list position for each specialty. She stated that many members of the public were very angry at the length of time they were having to wait for treatment and that this level of frustration could result in abuse to Trust staff. • LD suggested the process for x-rays through the Fracture Clinic needed to be reviewed and provided an example of a patient being given a date for an x-ray in a few weeks' time, but on calling the clinic then being allocated a cancellation appointment the next day. • It was acknowledged that it could be frustrating for patients to not understand how long they might need to wait for an appointment, noting that it could be difficult to predict as new patients might be prioritised above those already on the list.

	• In respect of waiting lists, JT explained that patients were prioritised, for example surgical waits from P1 to P4 with P1 being the most urgent. It was suggested it would be helpful for GP surgeries to also hold waiting list information. • JT informed the CoG that work was currently taking place to review how a patient was looked after once they were added to a waiting list in terms of contact with them and the output of this work would be shared with the CoG once it was completed. **Action: JT** • It was reported that guidance had been issued to ensure that in the future patients were given a named contact in respect of their ongoing care rather than needing to contract consultant secretaries. • The CoG was informed that the All My Planned Care website provided average waiting times by speciality for routine elective care and it was updated on a weekly basis. Torbay and South Devon Healthcare NHS Foundation Trust - My Planned Care NHS • The next Medicine for Members event was being held on the 20th October and would focus on Dermatology. • The Annual Members Meeting would be taking place on Wednesday 30th September and Governors were encouraged to attend the event. LD, with JOD and AS, would be hosting a drop in session for members of the public to attend and discuss any concerns they might have, or suggest improvements that could be made.
3.3	**Chief Executive's Report** The CoG received the Chief Executive's Report, circulated with the agenda pack. The following was discussed: • The Trust was currently managing a number of challenges including the transition of Adult Social Care to Torbay Council; Epic implementation and stabilisation, the latter of which was causing some performance and operational issues for the Trust; fire related incidents; changes to the Cellular Pathology model which was resulting in a lot of public interest; and organisational change programmes. • Over the past few weeks there had been record levels of heat and a number of heatwaves. This had resulted in a significant increase in emergency demand, impacting on ambulance waits, corridor care and patients needing to be located in day rooms. • A number of capital investment schemes were currently underway including new Cath Laboratories; Aseptic Pharmacy; and Maxillo Facial services building. • DC asked whether the Trust was on plan to recover the £31m deficit in respect of delivering Adult Social Services. JT explained this money was never planned to be this year as the Trust would continue to deliver the service until April 2027. At that point the Trust would continue to fund any health services provided to social care clients through joint arrangements. JT added that the transition was proving challenging given the length of time that teams had worked together, with fragility in those teams. • DC asked if the new robot was installed and commissioned. KL explained that before purchase the Trust had the robot on a 'try before you buy' basis and that it was operational and being used. It had recently been used to perform a day case bowel removal and once the patient had recovered, the surgery would be used as a good news story for the Trust.

	• AS queried the potential for legal challenge in respect of the Trust's decision to transfer the delivery of Adult Social Care back to Torbay Councill. JT explained that Torbay Council had considered a legal challenge but had decided not to take it forward. • MBI queried a recent temporary closure of urgent and emergency care services at Newton Abbot Hospital at 10 am and why Governors were not informed of the closure. It was noted that the executives present at the meeting were not aware of this so would respond to this query outside of the meeting. **Action: JT** • PK raised the delivery of Adult Social Care following the local government reorganisation and given a shadow council would be in place from April 2027, which would take over responsibilities from April 2028. The new organisation would encompass a wider South Devon footprint and PK raised a concern around the impact on delivery of social care. JT explained that the Trust already provided support to social care in the South Devon footprint and had been running in effect a two tier system for some time (with Torbay Council and Devon County Council) so he did not envisage the reorganisation impacting on the delivery of services.
3.4	**Membership Committee Chair's Report** The CoG received the Membership Committee Chair's report, circulated with the agenda pack.
3.5	**Governor Observer (GO) Exception Report** The CoG received the GO reports, circulated with the agenda pack. It was noted that some GO reports from recent Sub-Committees had not been included – these would be included in the next meeting agenda pack. **Action: KH**
4.	**GOVERNANCE**
4.1	**Governance Report** The CoG received the Governance Report, circulated with the agenda pack. The following was discussed: • Since the last meeting Councillor Dave Thomas had stood down from his role as Torbay Council's appointed Governor. The Trust was waiting for Torbay Council to appoint his successor. • The Governor election process was underway, with ballot papers being distributed on Tuesday 18th August. Vacancies in South Hams and Torbay were contested, those in Teignbridge were not. Disappointingly no one had put themselves forward for the vacancy in the Rest of the South West constituency. • Concern was raised around the potential suitability of candidates for the vacant positions. JH provided assurance there were no concerns with any of the candidates. • The Trust's 2025/26 Annual Report and Accounts had been laid at Parliament and published on the Trust's website. It was available here: Publications - Torbay and South Devon NHS Foundation Trust
4.2	**Trust Constitution** The CoG received the Trust Constitution, circulated with the agenda pack. The following was discussed:

	• CP reminded the CoG that the Health Bill was currently moving through the legislative process and was expected to be presented to the House of Lords in September. • The Bill introduced changes to the Foundation Trust model and the changes to the Trust's constitution being presented aimed to keep the Trust safe from a legal and regulatory basis when those changes came into force, which was currently expected to be 1st April 2027. • The proposed amendments also took account of the changes to the Trust's structure, with the removal of the Children and Family Health Directorate as the Trust no longer hosted this service, and changes that were planned to take place to the Trust's Care Group structure. • Importantly, CP was keen to work with Governors to co-design the framework that would need to be in place to enable the Trust to communicate with users of its services including hard to reach and vulnerable groups following implementation of the Health Bill. • The proposed changes to the Constitution would not remove current Governor responsibilities,only when the Health Bill became law. • GY raised a query around Neighbourhood Care Plans and how they would be implemented, with the need for a 'trusted organisation' to lead the work from a community perspective. JT acknowledged this and said the Trust, through its Strategy, had not assumed it would necessarily be the organisation to lead this work, however it would provide Governors with the opportunity to work with local partners to progress Neighbourhood Care Plans. The Integrated Care Board had not yet determined the model of delivery in Devon. **The Council of Governors:** • **Approved an enabling amendment to the Constitution that would take effect only if or when the relevant legislative provisions were enacted by Parliament;** • **Approved the replacement of the five existing staff classes with one Staff Constituency, retaining five elected staff governor seats and unchanged staff membership eligibility; and** • **Confirmed that Governors would be actively involved, alongside service users, carers, staff, community representatives and partners, in shaping and testing the Trust's future approach to engagement with its local population, drawing on their knowledge and experience.**
4.3	**CoG Self-Assessment Feedback** The CoG received the Self-Assessment Feedback report, circulated with the agenda pack. The following was discussed: • The self-assessment had been undertaken earlier in the year and covered the financial year 2025/26. • There appeared to be one or two governors who disagreed with each of the statements and it was suggested that where Governors disagreed it would be helpful to understand what improvements they thought could be made to address their concerns. • It was noted that some governors had some ideas around where improvements could be made but had not had opportunity to voice them. LD suggested the Governor Coffee Mornings, which had recently been reinstated, was a forum where these could be discussed.

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	• DC suggested that where suggestions were made, they were not acted on. It was noted that in some cases the Trust needed to be aligned to the majority if only one person had raised an issue. • VW suggested that the wording in future self-assessments be amended to be more specific, as that might help the feedback provided. • CP suggested two pieces of work took place: for each of the comments that had been received a 'you said, we did' template be provided for Governors to review, and another, more targeted self-assessment be undertaken in the autumn once new Governors had joined the Trust. **Action: CP**
5.	**GOVERNOR ENGAGEMENT**
5.1	**NED / Governor visits process** As previously discussed two NED/Governor visits had already taken place. It was suggested one-two governors attended each visit so as to not overwhelm departments. It was agreed that visits needed to be shared amongst Governors, and those that had already attended would not be first in line for future visits, until all interested Governors had had opportunity to attend visits. **Action: KH**
5.2	**Governor Communications Log** CoG received the Governor Communications Log circulated with the agenda pack, noting that it would be updated following the meeting to include responses to questions that had been omitted from the document.
6.	**INFORMATION ITEMS**
6.1	**Governor Calendar and Information Items** The CoG received the Governor Information items circulated with the agenda pack.
7.	**CLOSING MATTERS**
7.1	**Any Other Business** No further business was discussed.
7.2	**Close of meeting** The Chair declared the meeting closed at 15.46 pm.
7.3	**Date of Next Meeting:** Wednesday 11 November 2026 at 2.00 pm

Council of Governors
Action Tracker

No	Action	Lead	Due date	Update	Status
Meeting held on 12 August 2026					
1.	**Chair's Report** – provide detail of current number of vacant consultant posts and length of time they had been vacant.	**JT**	**Aug 26**		**Open**
2.	**Chair's Report** – Governor briefing to be reviewed to ascertain if additional information could be provided to ensure Governors were properly briefed on areas of interest, for example consultant recruitment.	**JT/JH**	**Aug 26**		**Open**
3.	**Lead Governor Update** – provide results of work taking place to review how a patient was looked after once added to a waiting list.	**JT**	**Sept 26**		**Open**
4.	**Chief Executive's Report** – investigate feedback regarding possible temporary closure of Newton Abbot Hospital.	**JT**	**Aug 26**		**Open**
5.	**Governor Observer report** – ensure missing governor observer reports were included in the next meeting pack.	**KH**	**Nov 26**		**Open**
6.	**CoG Self-Assessment** – provide a 'you said, we did' template for comments received as part of the self-assessment process, and run an additional targeted self-assessment in the Autumn.	**CP**	**Aug 26**		**Open**
7.	**NED/Governor Visits** – ensure visits were shared amongst interested Governors.	**KH**	**Aug 26**		**Open**

Actions recorded on this tracker should be grouped by meeting, with progress monitored at each subsequent meeting. Once complete the item should be marked as grey, noted by the Committee as complete and removed from the log before the following that meeting to ensure a proper auditable trail.

Report for November

We have once again had a busy three months since the last Council of Governors (COG) meeting.

We have welcomed five new Governors, and their induction day is scheduled for 2 October. We have continued to attend Patient Participation Group meetings at our local GP practices and have found these visits to be a valuable way of understanding the views of both patients and GPs regarding our hospital services.

We have also been actively promoting Trust membership through the various neighbourhood and community organisations to which we belong. We take seriously the campaign to raise awareness of the excellent medical services available within our Trust and are keen to support this whenever and wherever we can.

Those of us who attended the Annual Members' Meeting were pleased to assist throughout the day. This year's event, which was held at Paignton Library, was considered a success. We particularly appreciated the community location, which made the meeting more accessible for members of the public to attend. We also felt that the "marketplace" approach, showcasing the work of a number of hospital departments, was an excellent idea and provided attendees with valuable insight into the breadth of services offered by the Trust.

Our second major event was the Medicine for Members meeting, where Dr Rosie Davis, Consultant Dermatologist, delivered an excellent and informative presentation on skin conditions. The meeting was well attended by members, Governors, the Chairman and the Chief Executive Officer. The next Medicine for Members event is planned for April, and we hope to welcome a Consultant Ophthalmologist to speak about eye health and related conditions. We believe these meetings are an important way of highlighting the excellent work undertaken by our hospital departments and the dedicated staff who work within them.

Building relationships with our Non-Executive Directors (NEDs) continues to be a priority, and we greatly appreciate those NEDs who attend our priority meetings and support us with local issues and concerns. Governors and NEDs have participated in visits to Dartmouth, Teignmouth and Newton Abbot Hospitals, while a visit to Sherbourne House provided valuable insight into the work of community nursing teams and the care they deliver. Further community nursing visits are planned. We would also like to extend an ongoing invitation to any NEDs who wish to attend our constituency meetings, an initiative which has already begun successfully in Torbay.

Governors have continued to participate in the 15-Step Challenge walkabouts at Torbay Hospital alongside the Deputy Chief Nurse. A particular highlight was a visit to the Children's Ward, where we observed the excellent work being delivered through the collaboration of a range of multidisciplinary teams.

We have been encouraged to see improvements in both waiting times and the available space within the Emergency Department. However, we will continue to monitor this area closely, as it has historically been one of the greatest concerns raised by the public. We also remain focused on waiting times for inpatient admissions and first outpatient consultant appointments, which we intend to keep as a key priority over the coming year.

We are hopeful that the introduction of Epic will improve communication between hospital staff and our constituents by streamlining administrative processes and enabling staff to spend more time supporting patients. In particular, we would like to see telephones within clinical

departments covered by a medical secretary between 9.00 am and 5.00 pm on weekdays, thereby improving accessibility for patients and carers.

We remain committed to representing our constituents and continue to be actively engaged in a wide range of activities across the Trust. There will undoubtedly be many opportunities over the next three months for Governors to become involved and make a positive contribution.

Torbay and South Devon NHS Foundation Trust

Presented to:	**Council of Governors**					
Title of Report	Chief Executive's Report					
Date of Meeting	11.11.2026		**Author**	Jane Harris, Director of Communications		
Executive Lead	Joe Teape, Chief Executive		**Executive Sign Off**	03.11.2026		
Governance Route	N/A					
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
				X	X	
Executive Summary	This report provides the Council of Governors with an update on key developments, performance, strategic priorities and issues affecting our organisation and the wider health and care system.					
Recommendation	The Council of Governors 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 Governors with 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**

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

Compliance / Regulatory Requirements	Care Quality Commission Terms of authorisation, NHS England licence, and regulations National policy, guidance			
Ethical or EDI implications?				
Assurance rating	Significant	Moderate	Limited	Inadequate
Assurance rationale				

Appendices	Appendix A – Let's talk neighbourhood health services colleague insight report Appendix B – Shaping future neighbourhood health services: feedback from senior medical colleagues Appendix C - Torbay Hospital Tower Block – Fire Safety Improvement Programme

Torbay and South Devon NHS Foundation Trust

Executive summary

1. Over recent months we have continued to work through significant operational and financial pressures while making progress in a number of important areas. Urgent and emergency care performance has improved significantly, supported by changes in our emergency department, the new appointment priority system at Newton Abbot Urgent Treatment Centre and the opening of our Unscheduled Care Village at Torbay Hospital. There remains more to do, particularly on admitted pathways and reducing waiting times, but the progress made demonstrates what can be achieved when teams work differently around the needs of patients.

2. The position in our Tower Block has required considerable focus across the organisation. We are making temporary changes to services and reducing occupancy while strengthening fire safety arrangements, alongside a wider programme of physical improvements to the building. We have secured a further £8 million for fire safety improvements, in addition to the £1.8 million secured in September for fire safety works, while continuing to make the case for the longer-term replacement of the inpatient accommodation through the New Hospital Programme.

3. Alongside these immediate priorities, we continue to focus on improving access to planned care. Diagnostic performance has been improving and we remain committed to our revised recovery objectives for referral to treatment and 52-week waits. These improvements need to be sustained, particularly following the implementation of our electronic patient record, and reducing waits for patients remains an important priority.

4. Our financial position remains extremely challenging. We continue to work towards delivering our financial plan, but this will require significant further action, with additional pressures arising from the temporary changes needed in response to the Tower Block position. At the same time, we must continue to balance our immediate financial responsibilities with the investment and transformation needed to provide sustainable services for the future.

5. We continue to work with partners across Torbay and Devon on the future shape of health and care services. This includes developing neighbourhood approaches to care, wider system transformation and preparations for the transfer of adult social care responsibilities to Torbay Council. These changes are significant, and our focus remains on working with partners to ensure that services continue to meet the needs of the people and communities we serve.

6. Throughout this period, colleagues across our organisation have continued to respond with commitment, flexibility and a determination to improve care. Much of the progress described in this report has been achieved while teams are also dealing with considerable day-to-day pressures and change. I am enormously grateful for everything they continue to do for the people of Torbay and South Devon, and for the continued support and challenge of our governors as we work through the months ahead.

Torbay and South Devon NHS Foundation Trust

Performance dashboard

Medicine and emergency and urgent care
Emergency and urgent care

7. Urgent and emergency care performance has improved significantly since the position reported to governors in August, despite demand remaining high. Four-hour performance improved from 63.4% in August to 71.4% in September, although this remained below our operational plan trajectory of 76%. Improvement continued into the first half of October.

8. September was the fourth busiest month on record for Type 1 Emergency Department attendances, with 7,383 attendances. Despite this level of demand, the proportion of patients waiting longer than 12 hours improved to 12.2%, from 12.9% in August.

9. Ambulance handover performance has also improved. Average handover time reduced from 56 minutes in August to 39 minutes in September, while the number of handovers taking longer than 45 minutes fell from 887 to 548. Further improvement was seen during October.

10. Reducing corridor care remains an important priority. Improvement was seen during September and continued into October, although there remains more to do, particularly for patients who need to be admitted to hospital.

11. Our Same Day Emergency Care 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, helping more people return home the same day while keeping inpatient beds available for those who need them.

12. We have also introduced a new appointment priority service at Newton Abbot Urgent Treatment Centre in response to growing demand. People with urgent but non-life-threatening conditions can 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.

Planned care, cancer, diagnostics and support services
Planned care

13. Planned care performance remains challenging, although it is recovering following the implementation of our electronic patient record. Our September position showed 58.5% of patients waiting 18 weeks or less, ahead of our revised recovery trajectory of 57.7%, although below our original operational plan trajectory of 62%.

14. The overall referral to treatment waiting list stood at 31,775 patients in September, ahead of our waiting list forecast. We remain committed to improving

18-week performance and reducing the waiting list further, with recovery plans focused on increasing productivity, making better use of available clinic capacity and providing additional activity where needed.

15. Long waits remain a significant challenge, particularly within Ophthalmology and Trauma and Orthopaedics. At the end of September, 1,166 patients were waiting more than 52 weeks, and reducing these longest waits remains an important priority.

16. Work following the implementation of our electronic patient record has helped us better understand our waiting lists and address data quality issues. Overall our activity has now returned to pre-Epic levels, although further work is needed in some services to support the recovery in waiting times we need to see.

Cancer services

17. Cancer performance continues to present a mixed picture. Performance improved between May and August before falling back in September, with capacity pressures in dermatology contributing significantly to the deterioration.

18. Performance against the 28-day Faster Diagnosis Standard was 56% in September. Recovery has been seen in a number of specialties, including breast and gynaecology, although overall performance remains below plan.

19. Performance against the 62-day referral-to-treatment standard was around 65% in September, following performance of 70% in August. The overall backlog has continued to improve, although skin services account for a significant proportion of the remaining backlog.

20. Recovery work is continuing across the pathways experiencing the greatest pressures. This includes additional dermatology capacity, £65,000 of funding from the Peninsula Cancer Alliance to provide additional diagnostic capacity in gynaecology, and changes to breast pathways which have reduced waiting times.

Diagnostics

21. Diagnostic waiting times have continued to improve. In September, 21.3% of patients were waiting more than six weeks for a diagnostic test, compared with 39.4% in April and against a September trajectory of 21.4%.

22. There continues to be variation between services. CT, audiology, flexible sigmoidoscopy, gastroscopy and non-obstetric ultrasound were among the areas showing improvement in September, while DEXA, MRI and neurophysiology continued to experience particular pressures.

23. Additional DEXA capacity has been agreed through a mobile service from University Hospitals Plymouth and additional capacity continues to support recovery in non-obstetric ultrasound. MRI remains particularly challenged because demand continues to exceed available capacity, and options for additional capacity are being explored.

24. We have also 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 particularly supports older people living with frailty and others who may find it difficult to travel for an x-ray, helping to make diagnostic imaging more accessible and reduce unnecessary journeys to hospital.

25. Our latest UKAS assessment also showed significant improvement within Cellular Pathology, which is now reporting 94% of cases within 10 days, above the national standard of 90%. The assessment recognised the consistently high quality of Microbiology and Biochemistry services, while also highlighting workforce pressures within Haematology and Blood Transfusion.

Families and communities

26. Our community services continue to play an important role in supporting people to remain well and independent at home and reducing avoidable demand on hospital services. The latest performance information reported through the Finance and Operations Committee shows that our community waiting list is currently meeting the national NHS Oversight Framework segment 2 level.

27. We are continuing to strengthen how community performance is measured and understood. A community services performance framework has now been developed for inclusion within our integrated quality and performance reporting, giving us better visibility of access and performance across these services.

28. Our 0–19 Public Health Nursing service in Torbay has also retained its UNICEF UK Baby Friendly Gold Award following revalidation in September. Exclusive breastfeeding at six to eight weeks has increased from 35.5% when the service first achieved Gold to 40.9% at revalidation. The assessment also highlighted strong leadership and partnership working and the additional specialist capacity within the Infant Feeding Team.

Maternity services

29. Since 05 October, families using our maternity services have once again been able to have one person stay overnight on the postnatal ward. Overnight stays had been paused during the pandemic and their reintroduction follows feedback from families and our work with Devon Maternity and Neonatal Voices Partnership. Families told us that having someone with them overnight provides valuable practical and emotional support, including with bonding and infant feeding.

Leadership updates

30. Paul Richards leaves us this month 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 Torbay and South Devon, including through his leadership of our finance and performance committees and his longstanding support for our digital ambitions and Electronic Patient Record programme.

31. Paul has been a tremendous supporter of Torbay and South Devon and a consistent advocate for the people and communities we serve. He has worked

closely with our governors throughout his time with us, valuing their insight and challenge and making an important contribution to the work of our Council of Governors. He has brought considerable experience and constructive challenge to our discussions and has always been generous with his advice and support. We will miss him greatly and I would like to thank him for everything he has contributed over the past nine years.

Listening to our communities

32. In August, following our last Council of Governors meeting, we launched our Listening to our communities webpage, bringing together answers to some of the questions we hear most frequently from patients, local people, governors and stakeholders about healthcare services across Torbay and South Devon.

33. 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.

34. We have recently updated the page to add questions (and answers) about the tower block and maternity services.

Medicine for Members: skin health and skin cancer

35. I was pleased to join your 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.

36. 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.

37. I would like to thank Rosie, our governors and everyone who joined us for the event.

Annual Members Meeting 2026

38. It was good to see so many governors at 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.

39. 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/

40. 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.

41. For me, one of the most valuable parts of the day was taking the meeting out into one of the communities we serve. I hope we can build on that approach, creating more opportunities to listen and have open conversations with people across Torbay and South Devon.

Strategic priorities and risks

Planning 2026/27 & NHS England Oversight

42. 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.

43. 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.

44. 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.

45. 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.

46. 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

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

48. 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.

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

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

51. 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.

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

53. 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.

54. 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.

55. 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.

56. 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

57. 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.

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

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

60. 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

61. 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.

62. 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

63. 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.

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

Torbay Adult Social Care transition programme

65. 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. Our priority throughout remains a safe and well-managed transition for the people who rely on these services and the colleagues who provide them.

66. Progress is being made, although there are still important issues to resolve. These include staff transfer arrangements, service models, case reviews, funding responsibility and cost allocations alongside the development of the retained health model.

67. Supporting colleagues through this period of change remains particularly important. Work is continuing on the detailed arrangements for the transfer, alongside engagement with colleagues and trade unions as plans develop and greater clarity becomes available about what the changes will mean for individuals.

68. We are equally focused on maintaining the strong links between health and social care that have developed through Torbay's integrated model. While organisational responsibilities will change, people who use our services need joined-up care and support, and we will continue to work with our partners to ensure those relationships are maintained through the transition and beyond.

69. 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.

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

71. 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.

72. 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

73. 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.

74. 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%.

75. 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.

76. 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.

Radiotherapy services retain ISO 9001 accreditation

77. Our Radiotherapy Department has successfully retained its ISO 9001:2015 accreditation following an external assessment by the British Standards Institution (BSI). The assessment concluded that the department's quality management system remains effective, continues to achieve its intended outcomes and should retain certification.

78. The assessor highlighted the department's ongoing commitment to quality improvement and noted that quality is embedded throughout the service's processes. The report confirmed there were no outstanding findings from previous assessments and no new non-conformities were identified during the review.

79. The assessment reviewed a wide range of areas, including leadership and governance arrangements, risk management, patient pathways, clinical physics, regulatory compliance, patient experience and continuous improvement processes. It also recognised the continued development of the service, including preparations following the introduction of Epic earlier this year.

80. I would like to thank colleagues across radiotherapy, physics and cancer services for their continued commitment to delivering high-quality, safe and effective care for patients. Retaining ISO 9001 accreditation provides independent assurance of the quality of the service and the professionalism of the teams who deliver it.

Anaesthetic services achieve national reaccreditation

81. 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.

82. 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.

83. 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.

84. 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

85. 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".

86. 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.

87. 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.

88. 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.

Adult inpatient experience survey findings

89. The 2025 Adult Inpatient Survey gathers feedback from people aged 16 and over who spent at least one night in hospital, providing an important insight into people's experiences of inpatient care.

90. Overall, respondents rated their experience of care more highly than in the previous survey, with the overall score increasing from 8.2 to 8.4 out of 10. Across all 51 questions, results were rated as "about the same as most trusts", with no areas performing below the national benchmark.

91. People gave particularly positive feedback about the dignity and respect with which they were treated, the compassion of our colleagues, the cleanliness of our wards and their confidence in clinical staff. These results are particularly encouraging given the significant pressures many of our services continue to face and reflect the commitment and compassion of my colleagues to ensure patients are cared for and supported during their stay.

92. The survey also identified opportunities to further improve aspects of discharge planning and communication with patients and carers, which will help inform our ongoing improvement work. Patient feedback is one of the most important ways we understand what is working well and where we need to focus our efforts, and I would like to thank everyone who took the time to complete the survey.

Estate resilience, fire safety and emergency preparedness

93. The fire safety challenges in the Tower Block remain an important priority for us. I have attached as an appendix to this report our paper which went to our Board of Directors on 05 November which sets 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.

94. 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.

95. 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.

96. We also continue to strengthen our emergency preparedness arrangements across the organisation, building on the learning from incidents, exercises and reviews across our estate.

Capital investment programme

97. Work continues across a number of our capital programmes at Torbay Hospital. Much of this work is taking place while services remain operational, and I remain grateful to colleagues who are continuing to care for patients while adapting to significant building work and changes around them.

98. 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 07 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. The move will support a more straightforward journey for patients coming into hospital for planned surgery and help improve flow through our theatres.

99. 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.

100. Work is also continuing on the expansion of oral and maxillofacial surgery (OMFS) on level 2 at Torbay Hospital which will provide additional capacity and the new electrical substation, alongside the capital works needed to support the temporary service changes required to reduce occupancy of the Tower Block.

101. 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.

NHS England guidance on single-sex services and facilities

102. 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.

103. 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.

104. 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.

105. 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.

106. 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 Hospital League of Friends investment in patient monitoring

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

108. 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.

109. 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.

110. 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.

Research, innovation and access to new treatments

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

112. 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.

113. We have also secured £400,000 from the Torbay Medical Research Fund to develop the next generation of clinical researchers across Torbay and South Devon. The funding will provide three pre-doctoral and three doctoral fellowships over the next three years for colleagues working in nursing, midwifery, allied health professions, pharmacy and psychology, with the first cohort due to begin in April 2027.

114. This is an important investment in our longer-term research capability, giving colleagues opportunities to develop advanced research skills and generate

evidence that can improve care and outcomes for local people. We are proud to be the only organisation in the South West offering this level of research opportunity across such a broad range of professional groups. The Torbay Medical Research Fund was established by local medical practitioners in 1970 and we are extremely grateful for its continued support for research that benefits our communities.

115. 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.

116. 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.

117. 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.

118. 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.

Celebrating our Specialty and Specialist doctors

119. 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.

120. 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.

Our latest our people award winners

121. In late August we celebrated the latest winners of our quarterly Our People Awards, which recognise colleagues and teams who exemplify our values and go above and beyond for patients, families and one another.

122. This quarter's winners were:
- We are safe and healthy – Security and Enhanced Care Team, recognised for developing a proactive, patient-centred approach that improves safety and support for vulnerable patients with complex needs.
- We are compassionate and inclusive – Laura, Estates Business Support , recognised for the care, kindness and support she provides to colleagues across her department.
- We are always learning – Kate, Practice Education Facilitator, recognised for her leadership, compassion and commitment to learning and improvement while acting as Lead Midwife for Education during a particularly challenging period.
- We are a team – Emergency Department team, recognised for their resilience, adaptability and teamwork during a period of significant operational challenge and change.
- We work flexibly (joint winners) – Marie, Senior Specialist Dental Nurse and Hüseyin, Web Services Lead, recognised respectively for their commitment to patients and their support for carers and carers' services.
- We each have a voice that counts – Amanda, Advisor, recognised for her compassionate support for bereaved families and colleagues through complex statutory processes.

123. I would like to congratulate all the winners and nominees. Their commitment, professionalism and compassion demonstrate the values that underpin the care and support we provide every day across Torbay and South Devon.

124. We will announce our winners from the latest quarterly round later this month.

Nursing Times Workforce Awards

125. 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.

126. 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

127. 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

128. 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.

129. 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.

130. 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

131. 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.

132. 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.

133. 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.

134. 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

135. 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.

136. 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.

137. 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.

138. 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.

Remembrance and our Armed Forces community

139. 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.

140. 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.

141. 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.

Staff flu vaccination programme

142. 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.

143. 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

144. 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%.

145. 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.

System and partnership updates

Let's Talk Neighbourhood Health

146. 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.

147. 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.

148. 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.

149. 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.

150. 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.

151. 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.

152. 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.

153. 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.

Maternity services in North Devon

154. 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.

155. We understand this is a challenging situation for colleagues, expectant families and local communities in North Devon.

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

Local government reorganisation

157. The Government announced in July its preferred future structure for local government in Devon, with existing arrangements to be replaced by four unitary authorities, including an expanded Torbay authority. The proposals were subsequently paused by Government in September while they are reviewed.

158. Devon County Council has also been considering a legal challenge to the Government's decision. In September, the Council deferred a decision on whether to issue judicial review proceedings while it sought further clarification from Government about the review, while preserving its ability to pursue a challenge if required.

159. This means there remains uncertainty about the eventual arrangements and timetable. There are no immediate changes to council services while the future arrangements are considered.

160. Local authorities are key partners for the NHS, particularly in relation to adult social care, public health, housing and the wider factors that affect people's health. We will therefore continue to work closely with Torbay Council, our other local government partners and NHS Devon as the position develops, ensuring that we understand what any changes could mean for the people and communities we serve.

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

161. Recruitment for the permanent cluster Chief Executive for NHS Cornwall and Isles of Scilly and NHS Devon is underway.

162. Susan Bracefield is the interim Chief Executive.

Health Bill and local accountability

163. 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.

164. 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.

165. 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

166. 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.

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

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

169. 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.

170. 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

171. 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.

172. 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.

Livewell Southwest leadership changes

173. 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.

174. 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.

175. 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

176. 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.

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

178. We value immensely our partnership with South Devon College and Laurence has been a fantastic colleague who has championed Torbay and South Devon

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.

WorkWell Devon

179. A new Devon-wide WorkWell programme has recently launched to help people whose health is affecting their ability to stay in work, return to work or find employment. The programme provides personalised support and practical coaching to help people overcome health-related barriers to work and connect with services that may improve their health and wellbeing. It also works with employers and partner organisations to promote healthier and more supportive workplaces.

180. We welcome the programme's focus on the important relationship between health and work. For many people, good work contributes positively to physical health, mental wellbeing, independence and social connection. By supporting people to remain in or return to employment where appropriate, WorkWell has the potential to improve outcomes for individuals while contributing to healthier and more resilient communities across Devon.

Our Torbay and South Devon NHS Charity

181. 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.

182. 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.

183. 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.

184. 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.

185. 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.

186. 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.

187. 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.

Our Leagues of Friends

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

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

MP engagement

190. I continue to prioritise regular engagement with our local Members of Parliament to ensure they are fully briefed on our challenges, priorities, and the needs of our communities. I meet regularly with Caroline Voaden MP and Steve Darling MP while Martin Wrigley MP prefers a more ad hoc arrangement, but I always make sure to respond to his calls and emails in a timely manner. These meetings provide valuable opportunities to discuss local health and care issues, share updates on our strategic plans, and listen to the concerns and ideas of our elected representatives. Maintaining these open lines of communication helps us to advocate effectively for our services and the people we serve and ensures that our MPs are well informed and able to support our work at both local and national levels.

Governor engagement

191. I continue 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.

192. 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.

193. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past three months I appreciated being able to hear directly from colleagues at Paignton Health and Wellbeing Centre, 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.

194. During the past three 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.

195. 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.

196. 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, porters and waste, mortuary and OMFS service as well as with colleagues on EAU4 ward.

197. 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.

198. I have continued to meet regularly with pathology colleagues, along with fellow executives and senior leaders, as well as fortnightly meetings with histopathology (cellular pathology) colleagues as we progress a long-term solution for our routine histopathology service.

199. My routine meetings with the Integrated Care Board, NHS England, the Peninsula Acute Provider Collaborative, Torbay Council and our Council of Governors continue and provide valuable opportunities for discussion and to listen to diverse voices.

200. As ever, my many conversations with governors have been especially valuable, providing honest feedback, constructive challenge, and a direct link to the concerns and aspirations of our wider membership. These ongoing

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

201. I am pleased to welcome our new governors to today's Council of Governors meeting and look forward to working with all of you as we continue to progress our vision of supporting every person, family and community we serve to live well.

Look forward

202. As we head into winter, our immediate focus is on maintaining safe, good-quality care while continuing the improvements we have begun to see in urgent and emergency care and diagnostics, reducing waiting times and delivering our financial plan. Our winter plans bring together work across urgent and emergency care, vaccination, infection prevention and discharge, while the next phase of our urgent and emergency care work is focused particularly on patients who might otherwise need to be admitted to hospital.

203. The work required in response to the fire safety challenges in our Tower Block will be a major priority over the months ahead. During November and early December we will make a number of temporary service moves to reduce occupancy while maintaining services for local people, alongside progressing the programme of fire compartmentation work. While we have secured further national funding for this work, this does not change the longer-term need to replace the Tower Block through the New Hospital Programme.

204. At the same time, we must continue to look beyond the immediate pressures facing us. Work on neighbourhood health across Devon is developing, informed by engagement with patients, communities and colleagues about how services could work better together. There is strong support for prevention, earlier intervention and care closer to home where appropriate, alongside an important challenge to ensure these ambitions are supported by the workforce, capacity and infrastructure needed to make them work.

205. We will also continue to work closely with Torbay Council and the Integrated Care Board as we prepare for Adult Social Care services and associated resources to return to the Council on 1 April 2027. There is still considerable work to do, including on staff transfer arrangements, service models and funding responsibilities, and our priority remains a safe transition with clarity for the people who use our services and the colleagues who provide them.

206. Alongside this, we will continue to invest in the services and infrastructure our communities need for the future. This includes progressing the replacement of our cardiac catheterisation labs, developing a sustainable solution for Cellular Pathology and continuing work across our wider capital programme, while making the case nationally for the investment needed in our ageing estate.

207. Our role in Torbay and South Devon goes beyond the health and care services we provide. As one of the area's largest employers and an important

anchor institution, the decisions we make about how we employ people, develop skills, spend our money and work with partners can contribute to the health, wellbeing and prosperity of our communities. We want to make more of that role, particularly at a time when we know that people's wider circumstances have such an important influence on their health.

208. The Health Bill currently progressing through Parliament proposes significant changes to the way the NHS is organised and governed, including the future of councils of governors. We welcome the Government's recent decision to retain Healthwatch, recognising the importance of maintaining a strong independent voice for patients and communities. As we have discussed together, if the current arrangements for governors and membership are removed, we want to work with you to shape how we continue to hear and involve the communities we serve.

209. Governors also continue to have an important role in the work immediately ahead. We need your help to listen to and bring back what you are hearing from our staff and communities, to help people understand the changes taking place and why, and to challenge us where you think we need to think differently. Your connections across Torbay and South Devon are particularly valuable as we work through changes that will affect our organisation and the communities we serve.

210. There is a great deal to do over the coming months, and some of it will be difficult. Our focus must remain on what this means for the people we serve and for the colleagues delivering their care. I am grateful to our colleagues, volunteers, governors and partners for their continued commitment, and to governors for the insight and challenge you continue to bring during a period of significant change.

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.

NHS
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?

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.

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<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>

Torbay and South Devon NHS Foundation Trust

			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.

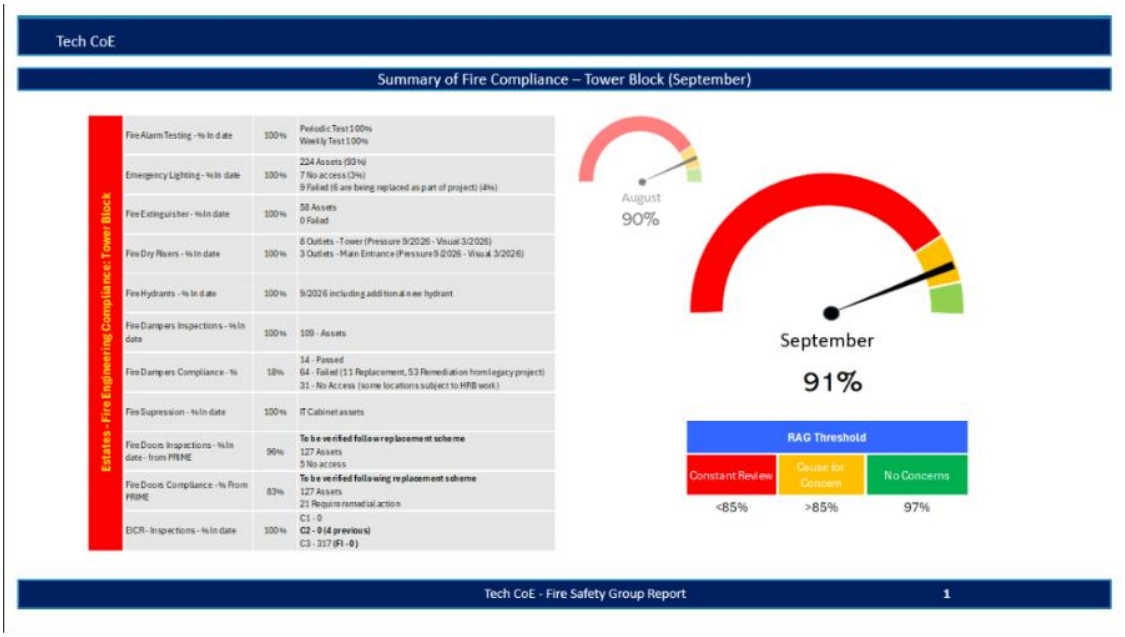
Our report to the September public Board described progress in these areas and identified where further physical improvements remained necessary. It also set out the further investment being made to improve fire safety within the Tower Block.

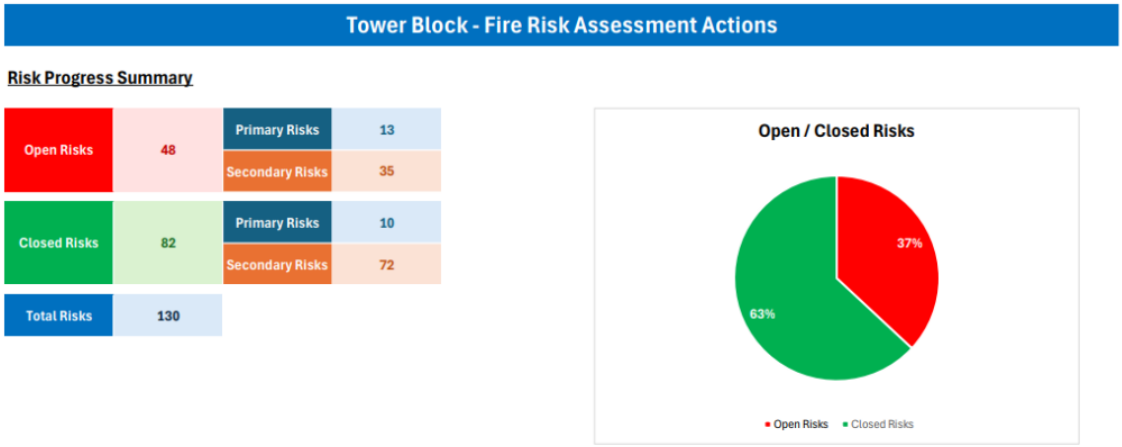
An updated fire engineering compliance position for September 2026 is illustrated below. The lowest area of compliance relates to fire dampers. Although the dampers continue to activate in the event of a fire, they do not currently meet the required inspection standard because they cannot be monitored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

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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.

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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

Report of the Membership Committee Chair to the Council of Governors

Meeting date:	22nd October 2026
Report by:	Loveday Densham, Chair, Lead Governor and Public Governor Torbay
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Council of Governors:

- **Annual Members Meeting** -
- **Medicine for Members -**
- **Some further updates on key actions were discussed -**.

Key decision(s)/recommendations made by the Committee:

Annual Members Meeting 2026

The Annual Members' Meeting (AMM) 2026 was held on 30 September at Paignton Library. The event was considered a great success, and we intend to continue holding future AMMs within the community to make it easier for members to attend and participate.
We were also pleased to receive positive feedback on the marketplace presentations and would like to thank all the staff who generously gave their time to support and contribute to the event. Next year, we plan to hold the AMM in a different locality and are currently exploring suitable venues for this purpose.

Medicine for Members

A successful *Medicine for Members* event was held on 20 October, featuring an informative and engaging presentation on Dermatology by Dr Rosie Davis. The talk was both educational and well received, with a good attendance from our membership.
Following the success of this event, we plan to continue these talks as an opportunity to showcase our clinical departments and highlight the excellent work they perform across the Trust.
The next event is planned for April, and the Ophthalmology Department has been invited to present and share the outstanding work which is carried out by their team.

Governor attendance to meetings and sending apologies –

All meetings have been quorate, but places are still available. In particular we would like governors from South Hams to volunteer to serve on this important Committee.

Increase in Membership numbers

To support this, we will actively engage with Patient Participation Groups (PPGs) at local GP practices. We encourage all members of the Membership Committee, and indeed all governors, to become involved with the PPGs at their own practices wherever possible.

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We also encourage governors to engage with local community organisations, particularly those that represent younger people and other underrepresented groups, to help ensure that our membership reflects the communities we serve.
In addition, we will explore how simple promotional materials and QR codes can make it easier for people to join and become involved.
In the meantime, membership application forms are available from Kirsty in the Trust Office.

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NHS Foundation Trust

Presented to:	**Council of Governors**					
Title of Report	Governance Report					
Date of Meeting	11 November 2026		**Author**	Membership Manager		
Executive Lead	**Associate Director of Corporate Governance and Trust Secretary**		**Executive Sign Off**	**Associate Director of Corporate Governance and Trust Secretary**		
Governance Route	N/a					
Purpose of paper	**For Approval**	**For Assurance**		**To Update**	**For Information**	
		x				
Executive Summary	This report updates the Council of Governors on key governance matters to support the discharge of its statutory duties.					
Recommendation	The Council of Governors is asked to receive and note the 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 the Foundation element of the Trust's strategy by enabling informed governor oversight, monitoring governance compliance and maintaining member representation and engagement. It also supports preparation for legislative changes affecting the Trust's governance arrangements.

Board Assurance			
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**
BAF-LG	Governance	8	The paper supports oversight of governance arrangements through updates on governor appointments, elections, compliance and legislative developments. Outstanding compliance matters, vacancies and potential legislative changes require continued monitoring. The information presented does not, in itself, justify a change to the current BAF risk score of 8.

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

Compliance / Regulatory Requirements	NHS Act 2006 (Schedule 7); the Trust Constitution and associated governor appointment, election and conduct requirements; and NHS England's Code of Governance for NHS Provider Trusts. The paper also supports CQC Well-led expectations for effective governance and accountability. Existing requirements remain applicable unless and until legislative amendments come into force.

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Ethical or EDI implications?	No adverse ethical or EDI impacts are identified in the report. Key considerations are transparent and fair governance processes, accessible member engagement and inclusive participation in governor elections. Vacancies and future governance changes should be considered for their effect on representation and the patient, public and staff voice.			
Assurance rating	Significant	Moderate	Limited	Inadequate
		X		
Assurance rationale	Moderate assurance is proposed, supported by governance oversight and delivery of the Trust's regulatory obligations.			
Appendices	Nil			

Torbay and South Devon NHS Foundation Trust

Introduction

This report updates the Council of Governors (CoG) on corporate governance developments, procedural changes and formal processes relevant to its responsibilities and operation. It outlines key activities, decisions and outcomes to support informed oversight and effective engagement.

1. Governor update – Appointed Governors

1.1 Following on from the last meeting Karen Barry, Appointed Governor for Integrated Care Board (ICB), resigned on 21 August 2026. The IBC have proposed a new candidate. The CoG will be advised when this appointment has been confirmed.

1.2 Following David Thomas's resignation as Appointed Governor for Torbay Council on 06 June 2026, the local authority has informed the Trust that it will not nominate a replacement Appointed Governor.

2. Governor Compliance

2.1 Governors who are not currently meeting their statutory requirements are as follows:

- Annual Declarations - Sarah Adams
- Mandatory Training – Sarah Adams
- CoG Attendance – Andrew Postlethwaite

3. Governors Elections 2026/27

3.1 At the previous meeting the Council of Governors were advised of the process for the 2026/2027 Governor Elections. These elections have been completed and one vacancy remains.

The following vacant seats have now been filled:

Public Governor	Torbay	Pat Harris
Public Governor	Torbay	Jo Rice
Public Governor	Teignbridge	Ollie Abercrombie
Public Governor	Teignbridge	David Palethorpe
Public Governor	South Hams	Jill Lawrence
Public Governor	Rest of the Southwest Peninsula	Vacancy

4. Annual Members Meeting

4.1 The Annual Members' Meeting took place on 30 September 2026, held at Paignton Library. Feedback on the event would be welcomed from those governors who were in attendance.

5. Update on Health Bill

5.1 As at 6 November 2026, the Health Bill has completed its passage through the House of Commons and is at Committee Stage in the House of Lords. The Lords

Second Reading took place on 13 October 2026 and Committee Stage began on 28 October 2026. The Bill remains subject to amendment and has not yet received Royal Assent. Further updates will be provided to the CoG as the Bill progresses.

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Presented to:	**Council of Governors**			
Title of Report	Self Assessment Update and Next Steps			
Date of Meeting	11 November 2026	**Author**	Associate Director of Corporate Governance and Trust Secretary	
Executive Lead	**Associate Director of Corporate Governance and Trust Secretary**	**Executive Sign Off**		
Governance Route	N/A			
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
	X			
Executive Summary	This paper updates the Council of Governors (CoG) on the response to its discussion on 12 August 2026 about the 2025/26 self-assessment. Governors identified three priorities: 1. clearer evidence of how feedback would be addressed. 2. opportunities to suggest improvements. 3. more specific questions in future assessments. The accompanying 'You Said, We Did, Next Steps' table in Appendix 1 sets out specific responses to each comment received within the self-assessment. The CoG is asked to collectively consider practical ways to improve two-way communication. These may include refinements to • the content, timing and accessibility of governor briefings, • routes for raising questions and sharing responses, • methods and routes to improve communication with members and local communities. These suggestions will inform a prioritised improvement plan, with named leads, timescales and a regular 'you said, we did' update so that progress and any outstanding issues remain visible to the Council. Action leads and target dates for Appendix 1 will be proposed following this meeting and submitted to the CoG for agreement alongside the improvement plan. A targeted follow-up self-assessment is proposed for quarter four of 2026/27 (January–March 2027), allowing newly			

	appointed governors sufficient experience to provide informed feedback. This revises the autumn timetable discussed in August. Questions would be more specific and invite practical suggestions for improvement. Building on the commitment made in August, the CoG is asked to approve a small, time-limited working group, with governors nominated by the Council to represent its views and supported by Corporate Governance and Communications colleagues. The group would co-design and test future engagement and communication approaches with service users, carers, staff, community representatives and partners, including people whose voices are less often heard. Once established, the group would propose its remit, key deliverables and reporting timetable for CoG approval. It would seek input from the wider Council through CoG Priorities and governor-only meetings, with proposals brought to the CoG for consideration before presentation to the Trust Board. This work would not change existing governor responsibilities.
Recommendation	The Council of Governors is asked to: 1. Note the response to the 2025/26 self-assessment set out in the 'You Said, We Did, Next Steps' table in Appendix 1. 2. Agree the revised timetable for a targeted follow-up self-assessment in quarter four of 2026/27, with more specific questions inviting practical suggestions for improvement. 3. Approve the establishment of a small, time-limited working group and nominate governors to represent the Council, supported by Corporate Governance and Communications colleagues, to co-design and test future engagement and communication approaches. 4. Suggest practical improvements to two-way communication, including governor briefings, routes for questions and responses, and communication with members and local communities, to inform a prioritised improvement plan with named leads, timescales and regular 'you said, we did' updates. 5. Agree that the working group will seek wider Council input through CoG Priorities and governor-only meetings and bring proposals to the CoG for consideration before presentation to the Trust Board, without changing existing governor responsibilities.

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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 the Foundation element of the Trust's strategy by translating governor self-assessment feedback into a prioritised improvement plan, strengthening two-way communication and making progress visible through regular 'you said, we did' updates. The proposed governor working group would help co-design inclusive engagement approaches so that the views of service users, carers, staff and local communities inform the Trust's strategic priorities and future service development. The targeted follow-up self-assessment would help evaluate progress and identify further improvements, while existing governor responsibilities remain unchanged.

Board Assurance

BAF Ref	Principal Risk	Current Score	Impact of this paper
BAF-LG	Governance	8	The paper supports mitigation of BAF-LG (Governance) by responding to governor self-assessment feedback and setting out proposed improvements to communication, engagement and accountability. The nominated governor working group, prioritised action plan and regular 'you said, we did' updates would strengthen oversight of delivery. Actions remain subject to implementation and evaluation through the targeted follow-up self-assessment; the paper does not, in itself, justify a change to the current risk score of 8.

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

Compliance / Regulatory Requirements	The proposals support the Council's responsibilities under Schedule 7 of the NHS Act 2006 and the Trust Constitution, including representing the interests of members and the public. The self-assessment response, improvement plan and follow-up assessment align with NHS England's Code of Governance for NHS Provider Trusts. The paper also supports CQC Well-led expectations for clear accountability, effective governance and continuous improvement. The working group would operate within an agreed remit and reporting route, without changing existing governor responsibilities.
Ethical or EDI implications?	The proposals should support inclusive engagement through accessible participation and fair working-group nominations. Ethical considerations include confidentiality, respect for differing views and transparency about how feedback informs decisions. Potential exclusion or under-representation should be assessed as the approach develops.

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Assurance rating	Significant	Moderate	Limited	Inadequate
		X		
Assurance rationale	Moderate assurance is proposed: Appendix 1 provides a documented response to self-assessment feedback and identifies further actions. Assurance remains qualified because the working group, prioritised improvement plan and revised communication arrangements require agreement and implementation. Regular 'you said, we did' updates and the targeted follow-up self-assessment in quarter four of 2026/27 will be needed to demonstrate delivery and evaluate effectiveness.			
Appendices	Appendix 1: 'You Said, We Did, Next Steps' table			

Appendix 1 – 'You Said, We Did, Next Steps' table

You Said	We Did	Next Steps
I think that the CoG is well supported and represented	We welcome this positive feedback. The Trust continues to provide administrative, governance and development support to help the CoG fulfil its statutory responsibilities.	We will continue to review the support provided and respond to governors' changing needs.
Processes are very clear	The feedback recognises the clarity of CoG processes.	Clear guidance and information about CoG processes will continue to be provided. Key processes and guidance will be reviewed periodically to ensure they remain accessible and up to date.
Overall, I am satisfied with the effectiveness of the Council of Governors. The environment encourages open, constructive dialogue and promotes collaborative working.	We welcome this positive assessment of the CoG culture and effectiveness.	The Chair, Lead Governor and Trust will continue to promote respectful, constructive and collaborative discussion.
Overall communication has been good. In my opinion the meetings run efficiently and meeting papers are thorough. I feel more engagement opportunities with the wider community would help governors fulfil their accountability role.	The feedback recognises the quality of meetings, papers and communication and identifies a need for more community engagement opportunities.	The paper proposes joint work with governors to co-design future communication and engagement approaches, including opportunities to engage with members and local communities.
We need better communication with the NEDs - they need to be more contactable and friendly it often feels like	Governor and NED visits are in place and continuing. An annual networking session also provides an opportunity for governors and NEDs to meet and	The Chair will encourage continued NED participation in Council meetings, visits and engagement sessions. The question process will

You Said	We Did	Next Steps
them and us with a sharp divide.	exchange views. The most recent session took place on 19 May 2026. A governor question process was reviewed and approved by the CoG in May 2026 to ensure questions are directed appropriately and responses are shared with the CoG.	be kept under review to ensure it supports open communication while maintaining appropriate oversight.
The NEDs could have a lot stronger presence in meetings and CoG is often not aware of their input other than committee work. I'd like to see more engagement between the NEDs and Governors.	NEDs attend CoG meetings where their commitments allow, and their committee responsibilities provide further opportunities to support and engage with the CoGs work.	The Chair will encourage NED attendance at relevant CoG meetings and engagement activities during 2026/27. Opportunities to improve the visibility of NED contributions will also be considered.
I think we need more interaction with the NEDs so that when we do their appraisals we can truthfully perform this task.	Governor and NED visits and annual networking sessions provide opportunities for interaction. Governors may also observe NED performance at public Board meetings. Governor observers attend Board committees and report relevant observations to CoG.	Existing opportunities will be better communicated, and further engagement between governors and NEDs will be encouraged to support informed appraisal feedback.
We need to have more engagement with the NEDs to be able to assess their performance and be good to see them in action at other Trust premises and to hear their open thoughts on the direction and sustainability of the Trust.	Governor and NED visits are continuing, alongside annual networking opportunities and governor attendance at public Board meetings.	Future visits and engagement sessions will seek to provide opportunities for discussion about strategic direction, sustainability and the contribution of NEDs.

You Said	We Did	Next Steps
Leadership of the CoG has been challenging. The person that steps forward to chair for this voluntary role needs to feel that they are supported from disrespectful vexatious repetitive allegations from other governors which undermine their appointed position and motivation. ie poor behaviour needs to be called out earlier and if a governor cannot understand that they have broken the principles then there should be the opportunity for a discussion, training and possible exclusion.	A new Lead Governor was appointed through a democratic process. Concerns about governor conduct were reviewed by the Chair and Senior Independent Director, and the outcome was reported to CoG. Information relating to attendance, training and other statutory responsibilities is now reported regularly to support transparency and accountability.	The CoG will continue to promote respectful and constructive working relationships. Concerns about conduct should be raised and addressed promptly through the appropriate process, with responsibility shared by all members of CoG.
We have spent too long on issues of conduct, at the expense of real Trust issues. Hopefully new leadership will give us more direction and purpose.	A new Chair and Lead Governor are now in place. The disruption experienced during the previous year has been acknowledged, and steps have been taken to address the issues raised.	Future agendas and workplans will focus the time on CoG's statutory duties, the Trust's strategic priorities and matters affecting members and the wider community.
With no lead governor and no constituency meetings I feel isolated and unsupported.	A democratic process was completed to appoint a new Lead Governor. The Trust acknowledges that this took longer than anticipated. Constituency meetings are governor-led, with support available from the Trust where appropriate. A Governor buddy system has been introduced and is working well and continues to offer support, especially	The new Lead Governor will work with governors to consider how constituency engagement and peer support can be strengthened. The arrangements and available support for governor-led meetings will be clarified.

You Said	We Did	Next Steps
	to the newly appointed governors.	
Too much time in this last year has been spent inward looking. Too much time spent on disciplinary issues. We have taken the eye off the ball.	The significant disruption experienced during the past year has been acknowledged. A new Chair and Lead Governor are now in place, and the disciplinary matters have concluded.	CoG forward work programme will place greater emphasis on strategic priorities, statutory responsibilities and engagement with members and the public.
I would appreciate being told of information that can affect myself in the instance of carer's representative so that I am able to clearly communicate with members of the public who wish to complain.	Governors are asked to signpost anyone wishing to make a complaint to the Feedback and Engagement Team. Governors should not investigate or manage individual complaints themselves.	Clear signposting information will be made available to governors so that members of the public can be directed promptly to the appropriate team.
We lack strategic direction moving forward. What has CoG achieved in the last 3 years?	During the past three years, the CoG has contributed to the appointment of the Chair and NEDs, approved the appointment of the Chief Executive, provided input into NED appraisals, supported membership activity and participated in Trust visits.	Further work will clarify the CoGs priorities and how it can best serve the local community.

ID	Date Requested	Governor	Constituency	Summary Description	Executive Lead	Response Date	Summary Response	C-O-G	Date emailed	Status
255	25.06.26	Mike Joyce	Teignbridge	should a patient be referred by a GP or other clinical specialist, to a specialist at Torbay NHS Trust, irrespective of the cause, what is the procedure to ensure that the patient is kept informed of the progress of the referral and the time scales involved.	Sam Wadham-Sharpe		Once a referral has been received and processed, the patient is placed on the appropriate waiting list for the specialty concerned. Patients are welcome to contact the relevant booking or waiting list team at any stage to request an update on the status of their referral and their current position within the pathway. While the Trust does not routinely issue a letter confirming placement on a waiting list, teams are available to provide information and support when contacted by the patient.Once a referral has been received and processed, the patient is placed on the appropriate waiting list for the specialty concerned. Patients are welcome to contact the relevant booking or waiting list team at any stage to request an update on the status of their referral and their current position within the pathway. While the Trust does not routinely issue a letter confirming placement on a waiting list, teams are available to provide information and support when contacted by the patient.	11.11.26	31.07.26	Responded
				How does any patient, who may not be IT compliance, be able to track the referral in question, be ensured that progress and time scales are being adhered to, and is there a list that is produced for each and every specialist area, to show this timescale and the number outstanding and duration			Patients who are unable or prefer not to use digital services can obtain updates regarding their referral and expected waiting times by contacting the relevant waiting list team by telephone. If patients are unsure which department to contact, they can call the Trust switchboard on 01803 614567, who will direct them to the appropriate service.			
256	26.06.26	Jake O'Donovan	Teignbridge	I appreciate that decisions relating to the future community hospitals involve several organisations, but I wondered whether you could provide an update on the Trust's understanding of the current position. In particular: -What is the latest position regarding services currently provided from Teignmouth Hospital? -If changes are planned, what reassurance can be given that local access to services such as physiotherapy and podiatry will be maintained where possible?	Sam Wadham-Sharpe	18.08.26	What is the latest position regarding services currently provided from Teignmouth Hospital? We recognise that there is significant local interest in the future of Teignmouth Hospital site and understand why people want clarity. As governors will be aware, plans had previously been developed for a new Health and Wellbeing Centre in Teignmouth town centre, with some services moving there and others relocating to Dawlish Hospital. In 2024 the decision was taken not to proceed with the health and wellbeing centre due to the costs involved. Following fire safety assessments, the first and second floors of the main hospital building are no longer able to be used, reducing the flexibility of the site. In response we are undertaking an options appraisal to consider the future of both the site and the services currently provided from it.	11.11.26	18.08.26	Responded
							The site contains the Teignmouth Hospital building and a building known as Teignmouth Clinic which is the former SureStart building (and was originally built as a nurses home). We served 12 months notice on the tenants in the Teignmouth Clinic building last year. Governors will be aware that earlier this month there was a fire in the Teignmouth Clinic building, this accelerated the planned relocation for these services as the building is now not usable. The community midwives have relocated to Dawlish Hospital and the Devon County Council Health Visitors are currently operating from both Teignmouth Hospital and Dawlish Hospital while longer-term arrangements. No decisions have yet been made about the long-term future of services currently provided from Teignmouth Hospital.			
							If changes are planned, what reassurance can be given that local access to services such as physiotherapy and podiatry will be maintained where possible? As part of the options appraisal, we are looking not only at the future of the estate, but also at how local people can continue to access care as close to home as possible. We know that services such as physiotherapy and podiatry are regularly used by local people and that travelling further for routine appointments can be difficult, particularly for older people and those with mobility challenges. A key part of the work underway is identifying which services should remain local to Teignmouth and where they could be based, alongside which services could be provided from Dawlish Hospital, reflecting previous planning assumptions for the area.			

							While no decisions have yet been made, a priority will be to retain local access for those services most frequently used by local people wherever it is possible, safe and sustainable to do so. If proposals are brought forward that would change where people receive care, we would engage with patients, colleagues, governors, councillors, the local MP and the wider community before any decisions are taken.			
257	29.06.26	Jake O'Donovan	Teignbridge	The constituent also shared concerns about waiting times for women's reproductive health services, including ultrasound appointments. Whilst I am not seeking information about any individual's care, it would be helpful to understand whether there are known pressures within these services and whether any work is underway to improve waiting times and patient access.	Sam Wadham-Sharpe		Thank you for getting in touch and for sharing the themes you have been hearing from constituents. We welcome feedback from Governors, as it helps us understand the issues that matter most to local people and provides valuable insight into how our services are experienced by patients and communities. You asked specifically about women's health services, including access to ultrasound appointments, gynaecology services and wider support for women experiencing reproductive health concerns. Regarding ultrasound services, it may be helpful to clarify that diagnostic imaging services are managed as trust-wide services rather than within the Women's Health Service itself. Non-Obstetric Ultrasound (NOUS) performance is reviewed monthly through the Trust's Diagnostic and Waiting Times performance arrangements.	11.11.26		Responded
				More broadly, I have noticed women's health beginning to emerge as a recurring theme in conversations with constituents in recent weeks, particularly around access to diagnostics, gynaecology and ongoing support. It would be useful to understand whether this is something the Trust is actively monitoring and whether there are any service developments or improvement programmes that Governors should be aware of.			The service experienced significant additional demand following the cessation of the Any Qualified Provider (AQP) service in March 2025. This service had previously provided community-based ultrasound activity commissioned directly by the Integrated Care Board (ICB), and its closure resulted in approximately 1,000 additional referrals being redirected to the Trust without a corresponding increase in capacity at that time. To address these pressures, additional funding was secured from the ICB in March 2026 to support recovery. The service is now working through the backlog and is on a recovery trajectory aimed at restoring the national standard that 95% of patients receive their diagnostic test within six weeks of referral. Current plans indicate that this standard should be achieved by January 2027.			
				I am not seeking information about this individual's care, but rather hoping to better understand the wider picture so I can respond accurately to constituents and ensure patient feedback is reflected in discussions about service performance.			More broadly, your observation that women's health is becoming a recurring theme in conversations with constituents reflects challenges being experienced nationally. We are very aware of patient concerns regarding access to gynaecology services, diagnostics and ongoing support, and these are areas that continue to receive significant attention within our organisation. As with many NHS organisations, demand for elective gynaecology services remains high and waiting times in some areas are longer than we would wish. We are actively monitoring these pressures and a range of improvement work is underway. This includes maximising available theatre capacity, improving productivity within outpatient and surgical pathways, regularly reviewing waiting lists to ensure patients are prioritised according to clinical need, and identifying opportunities to increase capacity where possible. Clinical teams also undertake ongoing waiting list reviews to identify patients whose circumstances may have changed and who require reassessment.			
							While progress is being made, we fully recognise the impact that prolonged waits can have on patients, particularly those living with chronic symptoms, uncertainty or reduced quality of life. Improving access to women's health services and reducing waiting times remains a priority for both the Women's Health Service and the organisation more widely. Thank you again for bringing these concerns to our attention. Themes identified through Governor engagement provide an important source of intelligence for the organisation, and we welcome continued feedback from you and your fellow Governors so that patient experiences can help inform service improvement.			

261	04.08.26	Vince Williams	Torbay	I would like to raise a formal governor assurance question concerning racist abuse and discrimination experienced by staff at Torbay and South Devon. Recent national reporting about racist abuse directed at NHS staff is deeply concerning. I recognise that governors need to focus on the evidence and assurance relating to our own Trust rather than assume that national findings automatically reflect the local position.	Jess Piper	09.09.26	Thank you for your question and for the careful attention you have given to the experiences of colleagues who encounter racism, racial discrimination, harassment, bullying or abuse. We recognise why this is an important issue for governors to raise. Racism and racial discrimination can have a significant impact on colleagues' wellbeing, psychological safety, engagement, retention and career progression. They can also affect people's sense of belonging and their confidence that they will be supported and protected by the organisation. The Board is clear that racism and racial discrimination are unacceptable, whether experienced from patients, visitors, members of the public, colleagues, managers or others. No colleague should feel that racism, abuse or intimidation is simply part of their job.	11.11.26	09.09.26	Responded
				The Trust's Workforce Race Equality Standard Annual Report 2026 provides sufficient local evidence to justify further discussion: https://www.torbayandsouthdevon.nhs.uk/uploads/wres-annual-report-2026.pdf?last-updated=20260522 The report records that: •946 employees, or 12.8% of the Trust workforce, were recorded as being from a Global Majority background, compared with 11.26% in the previous year.			The Board's understanding of this issue is informed by a range of sources. These include the Workforce Race Equality Standard, NHS Staff Survey findings, workforce data, incident reporting, Freedom to Speak Up reporting, employee relations information, staff network feedback, staff engagement, equality and inclusion reporting and wider cultural insight considered through the Trust's governance arrangements. These sources show that some colleagues from Global Majority backgrounds continue to report higher levels of discrimination, harassment, bullying and abuse than White colleagues. Our WRES report also shows that Global Majority colleagues report discrimination from colleagues at more than twice the rate reported by White colleagues.The Board therefore recognises racism and racial discrimination as an important workforce, culture and inclusion issue requiring active oversight. It is not seen solely as a matter of equality reporting, but as an issue affecting colleague safety, wellbeing, culture and retention.			
				•22.2% of Global Majority staff respondents reported experiencing harassment, bullying or abuse from patients, service users, relatives or the public. •15.7% reported discrimination from other staff, compared with 7.4% of White staff. •The report concludes that Global Majority staff continue to report higher levels of harassment and abuse from patients and the public, and discrimination from colleagues at more than twice the rate reported by White staff.			The Board also recognises that formal reporting is likely to underrepresent the true scale of colleagues' experiences. Some people may not report concerns because they are unsure what will happen, do not feel confident that action will be taken, fear negative consequences or have become used to tolerating unacceptable behaviour. For that reason, Board assurance is drawn from multiple sources rather than relying on a single reporting mechanism.The Board's assurance is not that the issue has been fully resolved. Rather, the Board has assurance that it is known, recognised, actively monitored and subject to ongoing action. It also recognises that further work is needed to strengthen reporting, data quality, staff confidence and the consistency of the organisational response.			
				I understand that Global Majority is the umbrella term used by the Trust. However, this category covers staff from a wide range of ethnic and cultural backgrounds whose experiences may differ considerably. The combined figures may therefore conceal greater levels of abuse or discrimination affecting particular groups. The report also does not identify how much of the reported harassment, bullying or abuse was specifically race-related. Nor does it distinguish between Global Majority staff generally and internationally recruited colleagues.			Our WRES report and NHS Staff Survey findings show that colleagues from Global Majority backgrounds continue to report higher levels of discrimination and abuse than White colleagues.The information available indicates that discrimination and abuse can be experienced from patients, service users, relatives and members of the public, as well as through workplace relationships involving colleagues and managers.The Board also recognises that experiences are not uniform across all groups. The term Global Majority covers a wide range of ethnic, cultural and personal experiences. Feedback suggests that the experiences of long-serving Global Majority colleagues may differ from those of colleagues who have arrived more recently, including some internationally recruited colleagues. Understanding these differences is important if we are to provide meaningful support and develop effective interventions.The Board's understanding is also informed by direct engagement with colleagues.			

				These are important gaps in the assurance currently available to governors. The Trust increasingly depends on a diverse workforce to deliver essential hospital and community services. It is therefore important that the Board can demonstrate that colleagues are safe, supported and treated with dignity, and that racist behaviour is consistently challenged rather than accepted as part of the job. I would therefore like the following question formally raised:			Through these conversations, we know that some colleagues have experienced racism and aggression not only within work settings, but also in the communities in which they live and work.Colleagues have described experiences including racist abuse, intimidation and hostility in public spaces. Local elected representatives, including Steve Darling MP, have also heard directly from some of our medical colleagues about their experiences. In some circumstances, the Trust has provided practical support to colleagues affected by racism or community hostility, including temporary emergency accommodation during periods of heightened local tension.These experiences reinforce the importance of ensuring colleagues feel supported, safe and valued both at work and within the communities they serve.			
				What assurance do the Non-Executive Directors have that the Board understands the scale, nature and impact of racist abuse and racial discrimination experienced by staff at Torbay and South Devon, and that incidents are consistently reported, acted upon and followed by effective support for the staff concerned? It would be helpful for the response to address:			Historically, incidents relating to racism and racial discrimination have been reported through a range of routes, including Datix, employee relations processes, Freedom to Speak Up, staff networks, Staff Side representatives, direct management reporting and informal escalation. As these systems have not previously been fully linked, the Trust has not held a single consolidated dataset capable of providing a complete three-year trend analysis of reported race-related incidents. The figures requested for 2023/24, 2024/25 and 2025/26 are therefore not available as a comprehensive and reliable dataset. The Board recognises this as an important limitation in the assurance currently available.In July 2026, the incident reporting categories were revised to better reflect the nature of incidents involving violence, aggression, abuse and behaviours that challenge.			
				•the number and trend of reported race-related incidents over the last three years; •whether incidents involve patients, visitors, colleagues or other sources; •whether particular services, occupations or staff groups are more affected; •whether the evidence can be broken down by specific ethnic group, where numbers allow this without identifying individuals; •whether internationally recruited staff have been considered separately; •whether the Board believes there is significant under-reporting;			Reporters can now select either "Behaviour that Challenges", where there are concerns regarding capacity, or "Violence, Aggression and Abuse", where no such concerns exist. A corresponding subcategory can then be selected, including discriminatory behaviour, physical assault, racial assault or hate crime, sexual assault and verbal assault.The revised categories should help incidents involving racism and discrimination to be identified, monitored and analysed more effectively. They also include additional information about department and role, although colleagues can continue to submit reports anonymously.As these changes have only recently been implemented, it is too early to determine their full impact on reporting patterns or to set out a reliable timescale for three-year trend reporting. The effect of the revised categorisation is being closely monitored through monthly reporting and governance escalation processes.			
				•what managers are expected to do when an incident occurs; •what support is offered to the member of staff concerned; •what action is taken against patients, visitors or staff responsible for racist behaviour; •how the WRES findings and resulting actions are monitored by the Board and its committees; and •whether staff have been asked directly whether they feel protected and supported by the Trust.			Evidence from the NHS Staff Survey, WRES reporting, incident reporting and staff feedback indicates that discrimination and abuse can involve patients, service users, relatives, visitors and members of the public, as well as colleagues and managers.This demonstrates that racism and racial discrimination are not confined to interactions with patients and visitors. The Board recognises the need for a whole-organisation approach which addresses behaviour from members of the public and within workplace relationships.Our Staff Survey data also indicates that experiences of harassment, bullying, abuse and discrimination are not shared equally across ethnic groups. Black or Black British colleagues report the highest rates across several measures, particularly where incidents involve patients, service users and members of the public. Where discrimination is reported by Black and Asian colleagues, more than 90% of respondents in the ethnicity groups shown below identify race as the reason for that discrimination.			

				I am not seeking details of individual cases. Any information provided should be aggregated and anonymised. I appreciate that this may be an uncomfortable matter to discuss, but that should not prevent governors from seeking clear evidence and assurance. This is not an allegation that every reported incident was racist, nor is it criticism of individual patients, staff or services. It is a request to understand the local evidence, identify any gaps and establish whether the Trust's response is effective.			The Board is clear that racism and racial discrimination have no place in our organisation or in the communities we serve.We know from workforce data, formal reporting, colleague feedback and direct engagement that some members of our workforce continue to experience racism, discrimination and hostility. We also recognise that formal reporting is unlikely to tell the whole story and that experiences vary significantly between different ethnic groups.The Board has assurance that this issue is recognised, actively monitored and subject to ongoing action. However, there are important limitations in the assurance currently available. The Trust does not have a consolidated three-year dataset of race-related incidents, cannot yet provide reliable analysis by service or occupation, does not consistently identify the experiences of internationally recruited colleagues separately and does not currently have a comprehensive measure of whether colleagues affected feel protected and supported.Work is under way to address these gaps. This includes embedding and monitoring the revised incident reporting categories, bringing together different sources of intelligence, strengthening staff networks and escalation routes, reviewing relevant policies, improving manager guidance and capability, progressing the It's Not OK campaign and responding to the national recommendations on anti-racism and			
262	10.08.26	Olivia Bath	Staff Governors	With the impending restructuring of management roles Band 5 and above, please could you provide any assurance for staff on bands 2, 3 or 4 with regards to if their jobs are secure, the potential changes to their roles and also departments where they are understaffed, particularly in trauma and orthopaedics, that they will be provided with the support that they need. There are staff members who have expressed that the stress of their day jobs is affecting their mental health and wellbeing outside of work.	Jess Piper	14.08.26	We recognise that the number of organisational change programmes currently underway across the Trust can feel unsettling for staff, and we understand the uncertainty this can create. These programmes are being undertaken to ensure we have the right people, with the right skills, in the right roles, enabling us to improve performance, strengthen our services and provide the best possible care for our patients. At present, the management restructure relates to Band 5 and above posts. No decisions have been made regarding Bands 2, 3 and 4 as part of this process. However, following the implementation of Epic, the Trust recognises the need to review administrative and support functions across the organisation to ensure roles, responsibilities and ways of working are aligned to future service needs. This work is still being developed, and any proposals that may affect staff would be subject to appropriate engagement and consultation before any changes are implemented.	11.11.26	14.08.26	Responded
263	10.08.26	Olivia Bath	Staff Governors	From discussions I have had, there seems to either be a lack of career progression within Torbay Hospital or it is not signposted, many years ago there were many more opportunities to attend courses, shadow other team members and for staff with departmental experience and knowledge to progress. Please could you provide some assurance as to what opportunities there are for administrative staff band 4 and below, to progress within Torbay Hospital, along with the consideration of merit to be a recognised with those opportunities.	Jess Piper	14.08.26	Thank you for raising this important point. We recognise that career development opportunities for administrative and support staff have not always been visible, and that this can create a perception that progression opportunities are limited. The Trust is committed to supporting career progression for all colleagues through a range of development opportunities, including apprenticeships, accredited qualifications, leadership and management programmes, coaching and mentoring, secondments, project work, and access to wider learning and development resources. In addition, the planned development of the Learning Academy is intended to provide a more coordinated and transparent approach to career pathways, making opportunities easier to access and navigate.	11.11.26	14.08.26	Responded
							We also acknowledge the value of experience, departmental knowledge and demonstrated performance. Whilst appointments to new roles must be made through fair and transparent recruitment processes, we are committed to ensuring that staff are supported to develop the skills, experience and qualifications needed to progress. This includes promoting access to development opportunities, encouraging internal career conversations, and better signposting available pathways. As part of our ongoing work, we will continue to review how career opportunities are communicated and explore how we can strengthen progression pathways for administrative and support staff, ensuring colleagues can see a clear route for development and advancement within the Trust. If you require any further information please do not hesitate to contact the education teams who can direct your enquiry tsdft.cpdapplications@nhs.net			
264	10.08.26	Olivia Bath	Staff Governors	Please could you provide an explanation as to why no medical secretaries received VR, as I have received feedback from multiple secretaries that applied, that VR was not approved for them.	Jess Piper	14.08.26	We understand colleagues' interest in the outcome of the Voluntary Redundancy (VR) scheme, particularly for administrative roles. Applications were assessed on a case-by-case basis, taking into account service requirements, workforce risks and operational impact. We are also mindful of the pressures that some teams are experiencing, including areas where staffing levels remain challenging. Throughout any change process, we remain committed to supporting services to maintain safe and effective staffing and to identifying where additional support may be required.	11.11.26	14.08.26	Responded

							We recognise that change and uncertainty can have an impact on health and wellbeing. We would encourage any colleague who is feeling affected to speak with their manager and access the range of wellbeing support available through the Trust, including the Employee Assistance Programme, Occupational Health and other wellbeing resources. Supporting our staff through periods of change remains a priority, and we are committed to keeping colleagues informed as plans develop.			
265	26.06.26	Jake O'Donovan	Teignbridge	I have recently been contacted by a constituent regarding the ophthalmology injection service, and I wanted to share their feedback and ask a couple of questions to help me better understand the current position. The constituent, who is receiving treatment for wet macular degeneration, told me they have been waiting 16 weeks since their last injection and have been advised that appointments are currently running around four weeks behind schedule.	Sam Wadham-Sharpe	20.08.26	We apologise that the patient has experienced a delay in receiving their intravitreal injections. If the patient is willing to provide identifying details, such as their name and date of birth, we would be pleased to review their individual circumstances and determine whether an appointment has already been arranged or identify the earliest available opportunity for treatment. The ophthalmology injection service is currently experiencing increased pressure on appointment availability due to a backlog of patients requiring treatment. A number of factors have contributed to this position. There has been variation in the number of appointments that different staff members have been able to undertake, largely due to differing levels of training, experience and confidence. This has been recognised and is being addressed through additional support, training and clearer expectations regarding clinic	11.11.26	20.08.26	Responded
				They understandably expressed concern about the potential impact this could have on their eyesight. They were also keen to emphasise how highly they regard the staff in the department, recognising the pressures they are working under and describing them as "amazing". Whilst I appreciate this is one individual's experience and there may be clinical factors specific to their care, it does reflect a broader theme I have heard from a number of residents regarding ophthalmology waiting times.			activity. As staff continue to develop their skills, capacity is increasing, but this must be managed carefully to ensure patient safety is maintained at all times. The introduction of Epic has also had an impact on clinic productivity. As with any major system change, appointment times initially increased and clinic capacity reduced while staff adapted to new ways of working. The Epic team has been working directly with the service and is providing further support and training to ophthalmology staff to help improve efficiency and increase appointment availability. We are also exploring the introduction of insourced injection clinics to help reduce the backlog. Alongside this, the service is reviewing demand and capacity to ensure that, once the backlog has been addressed, we have sustainable arrangements in place to meet future demand and offer appointments as close as possible to patients' clinically agreed treatment dates.			
				I wondered if you could help me understand: •Is there currently increased pressure on the ophthalmology injection service resulting in longer waits for some patients? •If so, what are the main factors contributing to those pressures? •What steps is the Trust taking to improve capacity and reduce delays? •Is there any wider update that Governors can share with members of the public who raise similar concerns?			We fully recognise the impact that delays can have on patients and are very sorry for the inconvenience and anxiety this may cause. A range of measures is now being implemented to improve capacity and reduce waiting times, and we are hopeful that these actions will enable us to return to a position where patients can receive their injections on, or much closer to, their planned treatment dates.			
				I am not seeking information about this individual's care, but rather hoping to better understand the wider picture so I can respond accurately to constituents and ensure patient feedback is reflected in discussions about service performance.						
266	12.08.26	Olivia Bath	Staff Governors	As previously discussed regarding waiting lists at the previous governor meeting, I think there is also a misunderstanding of particular referral processes, this being specific with referral to secondary care for specific services, especially the ESP Services, which means that the patients are not understanding of the process, wait times involved in each part of the pathway, and their expectations are then not met.	Sam Wadham-Sharpe	20.08.26	We recognise that some referral pathways, particularly for musculoskeletal conditions such as knee and hip problems, can involve several stages before a patient reaches a surgical consultation. This can understandably be confusing if patients are not clear about what to expect and the likely waiting times at each stage. Historically, patients received information about the next step in their pathway and the expected wait before their appointment. Following the introduction of Epic, some referral processes have changed and we are reviewing how best to ensure patients continue to receive clear and timely information throughout their journey.	11.11.26	20.08.26	Responded

				Is there a way to make this readily available to the patient, so that they can be directed to the information by Primary Care Services, so that they know what to expect prior to them starting the NHS pathway for e.g. a knee replacement, as it is not as straightforward as a direct GP referral to Secondary Care, which aligns with the complexity of the wait times that was mentioned at the meeting.			We agree that providing patients with a simple explanation of the pathway, including the different stages they may move through and indicative waiting times, would help manage expectations and improve understanding. We will explore opportunities to make this information more readily available, including through our website and information shared by primary care colleagues at the point of referral. Our aim is to ensure patients understand where they are in their pathway, what happens next, and who to contact if they have questions.			
267	04.08.26	Andrew Postlethwaite	Teignbridge	Volunteer Car Transport Service. At a recent meeting within my constituency, I was made aware of the dire situation this organisation finds itself in. This has largely come about due to the increasing numbers of times a transport appointment is cancelled. They do not get any compensation for cancellations. Consequently, they are near to collapse, with the likely loss of this vital service. Are the Trust aware of this situation? Do they have any contingency measures should this service cease?	Sam Wadham-Sharpe/Simon Tapley	02.11.26	Thank you for your question regarding the impact that short-notice appointment cancellations may have on local volunteer car transport services, particularly in the Dawlish area. We recognise the valuable contribution that volunteer and community transport organisations make in supporting patients to attend healthcare appointments, particularly those who may otherwise struggle to access services. We understand the concerns that have been raised regarding the effect that cancelled appointments can have on these organisations and the inconvenience and frustration this can cause for both patients and volunteer drivers. The Trust works hard to avoid cancelling appointments at short notice wherever possible. However, there are occasions when cancellations are unavoidable. The most common reasons include unexpected clinician sickness, unforeseen operational issues that affect clinic or theatre capacity, and wider service disruptions that can arise at short notice.	11.11.26	02.11.26	Responded
				Is the Trust able to offer the Volunteer Car Transport service some reassurance that it will investigate the way transport services are commissioned and how cancellations are handled?			Industrial action has previously created circumstances where planned care activity has needed to be stood down at short notice. These situations can make it difficult to provide patients with more notice of cancellation. When cancellations are necessary, our teams aim to contact patients as early as possible and make every effort to minimise disruption. We continually review our processes to reduce avoidable cancellations and improve communication with patients regarding any changes to their appointments. With regard to community transport services, these organisations are generally independent voluntary or charitable providers and are not directly commissioned by the Trust. As patients arrange transport directly with these providers, the Trust is not always aware of transport bookings that have been made when appointments require rescheduling. While we are not currently aware of specific concerns regarding the sustainability of individual volunteer transport services, we recognise the importance of these services to our communities.			
268	04.08.26	Andrew Postlethwaite	Teignbridge	Recently I have been receiving hydrotherapy sessions at Torbay Hospital. The working environment in this facility is quite oppressive, particularly in the recent heatwaves. A combination of heated pool and hot weather combine to make it quite an unpleasant environment. I understand they do have air handling equipment within the space, but it is currently not working. What are the trust's plans to remedy this situation and when can the employees hope to have an acceptable working environment?	James Corrigan	11.09.26	There are issues around ventilation in the Hydrotherapy Pool. These have been discussed with Associate Director – Estates Infrastructure and Compliance, and Service Manager. We are working to remedy the issue.	11.11.26	11.09.26	Responded
270	24.08.26	Mike Joyce	Teignbridge	I would wish reassurance that following the comment below, that the appropriate remedial action has been put in place and that Governors are able to see in what respect this has happened, to satisfy ourselves that it has been. "A coroner's report into the death of a 70-year-old man at Torbay Hospital has highlighted 'a gap in cover which puts patients at risk'.	Joe Teape	28.08.26	Devon's Coroner has issued a Regulation 28 Prevention of Future Deaths (PFD) Report to NHS Devon ICB following the inquest into the death of Mr John Cleave at Torbay Hospital in December 2023. The report was directed to the ICB rather than the Trust and focused on the availability of consultant radiologist expertise overnight across Devon hospitals and the potential impact on the interpretation of complex imaging. Following Mr Cleave's death, we undertook a Serious Incident investigation which identified several contributory factors, including delayed escalation to senior decision-makers, a lack of clarity around clinical responsibility for the patient's care, and issues relating to transfer arrangements to specialist services. Learning from the investigation has been reviewed through established patient safety processes.	11.11.26	28.08.26	Responded

							The Coroner's findings prompted discussion about access to consultant radiology expertise overnight and the impact of information sharing between organisations. The ICB's response confirmed that consultant radiologist support is available 24 hours a day across Devon's acute trusts and the wider Peninsula network through on-call arrangements, and that providers will review escalation pathways and assurance processes for out-of-hours imaging interpretation, particularly in major trauma and other complex cases. The inquest also heard that the introduction of Epic across Devon providers improves access to imaging and clinical information, supporting real-time clinical decision-making across organisational boundaries.			
							The matter received media attention following publication of the Coroner's findings by DevonLive. While our radiology leaders contributed to the ICB's response, we were not sighted on the final response before submission. This has highlighted a governance learning point and NHS Devon ICB has been asked to ensure that future PFD reports relating to our care are routinely shared with relevant executive leads to support appropriate oversight, assurance and stakeholder briefing arrangements.			
271	01.09.26	Lee Thomas	Torbay	I note that the minutes of the July 2024 Public Board meeting stated that the Trust was working with Torbay Council on the "construction and delivery of two solar parks", which were expected to provide a greater part of the Trust's electricity. Could the Trust please provide an update on these schemes and, in particular, the proposed Nightingale Park solar farm? Could the Trust confirm: •Whether Nightingale Park was one of the two solar parks referred to in the July 2024 Board minutes, and what the second scheme was.	Caroline Cozens	18.09.26	The July 2024 Board minutes refer to two solar park projects. However, we have been unable to identify any supporting reference to two solar parks in the Workplace Strategic Board report (which is the minute is in relation to) and the colleagues who presented the update to Board are no longer with the organisation. We can confirm that Nightingale Park is the only solar park project currently being developed by us with Torbay Council. We have not been able to verify the basis for the reference to two solar parks from the records available to us. The project continues to be developed jointly by Torbay Council and ourselves. Before it can move to the next stage, a number of commercial and legal agreements need to be finalised between the two organisations.	11.11.26	18.09.26	Responded
				•What the current status of the Nightingale Park project is. •Whether all necessary agreements between the Trust and Torbay Council, including arrangements for the Trust to purchase electricity generated by the site, have now been agreed and signed. •If agreements remain outstanding, what matters are still to be resolved and whether these sit with the Trust, Torbay Council or both organisations. •Whether the Trust remains committed to taking electricity from the Nightingale Park scheme.			Once these agreements are in place, Torbay Council will be able to begin the procurement process to appoint a delivery partner. Based on current assumptions, the solar park could become operational around 18 months after a contract is awarded. No, not yet. We have agreed the key principles of how electricity generated by the site would be supplied to Torbay Hospital. However, a number of detailed commercial and legal agreements still need to be completed and signed before the project can proceed. A number of commercial and legal agreements are still being finalised by both organisations. These include the arrangements covering electricity pricing, land use and the long-term supply of electricity from the solar park to us. The remaining work requires input and agreement from both Torbay Council and ourselves before the project can move to the next stage. We remain supportive of the Nightingale Park project and continue to work with Torbay Council to progress it. However, neither organisation will be formally committed to the long-term arrangements until the outstanding commercial and legal agreements have been completed.			
				•What the current anticipated timetable is for construction and for the solar farm to become operational. •What have been the principal reasons for the delay, given that the Trust was already referring publicly to the "construction and delivery" of the solar parks in July 2024. •Whether delays or changes in project cost have altered the anticipated financial savings or carbon-reduction benefits to the Trust. •Whether there is now any material risk that the Nightingale Park scheme will not proceed.			The project was first announced publicly by Torbay Council in May 2022, following approval of planning permission for the Nightingale Park solar park. At that stage, while Torbay Council had begun discussions about the potential use of electricity generated by the site to supply Torbay Hospital, no formal commercial agreements were in place. Since then, the project has required further development work to address matters including the site's previous use as landfill, ground conditions, environmental requirements, electricity grid connection arrangements and the commercial and legal agreements needed between Torbay Council and ourselves. A significant element of the programme has been the development of the commercial arrangements that would underpin the long-term supply of electricity to us. These arrangements are still being finalised and remain necessary before the project can move to the next stage.			

				I would also like to ask whether the wider potential of the Nightingale Park site has been considered in the context of the significant parking pressures at Torbay Hospital. Given its proximity to the hospital, have the Trust and Torbay Council considered whether part of Nightingale Park could provide additional staff, patient or visitor parking alongside the renewable energy scheme?			We remain supportive of the Nightingale Park project and continue to work with Torbay Council to progress it. However, neither organisation will be formally committed to the long-term arrangements until the outstanding commercial and legal agreements have been completed. The timetable depends on the remaining agreements being completed. Once these are in place, Torbay Council will be able to begin procurement and appoint a delivery partner. Based on current assumptions, the solar park could become operational around 18 months after a contract is awarded.The project is still expected to deliver both financial savings and carbon reductions once operational. Although project costs and energy prices have changed since the scheme was first developed, the benefits of generating renewable electricity locally remain significant.			
				For example, has any consideration been given to: •providing parking on an appropriate part of the site; •using the site for staff parking or a park-and-walk / shuttle arrangement, thereby freeing spaces on the main hospital site for patients and visitors; •incorporating parking and solar generation together, including the possibility of solar canopies above parking areas; or •other uses of the site which could support the hospital's longer-term estates and transport requirements?			As with any major infrastructure project, there are risks that could affect delivery. The main risks at this stage relate to completing the remaining commercial and legal agreements and successfully appointing a delivery partner. However, there is currently no indication that Torbay Council intends to withdraw support for the project and we continue to support it - both organisations remain committed to progressing it.			
				If parking at Nightingale Park has been considered and ruled out, could the Trust explain the main constraints, for example ground conditions associated with the former landfill, planning requirements, access/highways, ecology or cost? More broadly, given that Nightingale Park is a substantial publicly owned site immediately adjacent to the Torbay Hospital area, could the Trust confirm whether it and Torbay Council are looking strategically at the future use of the site as a whole, rather than solely considering it as a solar-generation project?			Yes. We have explored whether the site could support additional parking as well as renewable energy generation. However, the site's previous use as landfill creates significant challenges. Any parking development would require substantial engineering work to protect the landfill cap, together with new access roads and other infrastructure. When these costs and complexities were assessed, a combined solar and parking scheme was not considered to offer sufficient value for money.			
272	09.09.26	Andrew Stilliard	Torbay	My enquiry is on behalf of constituents using the above car park on a Sunday when the car park is empty. They have had an arrangement for some years to pay a quarterly fee which has worked well. Id like to understand why this is being withdrawn from the end of September. They use the parking to attend their church and as elderly folk find it most helpful. They would very much like it to continue.	James Corrigan	18.06.26	Thank you for your email. The arrangement in question is a historic agreement under which the church pays £193 per quarter for ten parking spaces, together with additional spaces for guest speakers attending services. This arrangement was originally established at a time when there were very limited alternative public parking options available locally. Since then, alternative public parking provision has become available at the former Crossways Shopping Centre site, which is located directly opposite the church. In addition, we are currently reviewing a number of safety concerns relating to the rear area of the Paignton Health and Wellbeing Centre car park. These issues may necessitate the closure of all or part of the car park in the future while appropriate measures are considered and implemented, which include capital investment. Given the availability of alternative parking and the uncertainty regarding the future	11.11.26	18.09.26	Responded

273	16.09.26	Mike Joyce	Teignbridge	can Governors, especially those in Teignbridge, be reassured that adequate arrangements are in place to deal with any influx of referrals, how the Parking at NA Hospital is going to cope with this influx and has consideration been given to the impact on NA Hospital resources and the residents living within that area, as in the past, parking has become a real problem and frustration for many	Sam Wadham-Sharpe	25.09.26	Governors can be reassured that the proposed changes are in response to the increasing demand experienced at the UTC so far this financial year which is roughly 14%. The moved to planned appointments is in line with national guidance and is aimed at creating a more consistent demand profile. We do not anticipate an increase in the overall number of patients attending urgent care services as a result of the proposed changes at the UTC as the revised booking arrangements are intended to improve access and patient flow rather than generate additional demand. As a result, we would not expect any significant impact on car parking capacity at Newton Abbot Hospital. However, we will continue to monitor car parking activity levels to ensure that any unforeseen pressures are identified and addressed promptly.	11.11.26	25.09.26	Responded
274	08.10.26	Mike Joyce	Teignbridge	I have just, as a Councilor, come off a ZOOM presentation by Rural Services Network, I found it was very interesting, especially hearing from others through out the UK, on the various challenges they, in rural areas, are facing and how this network is using its collective voice to highlight these challenges and get MP's and others on side. Sevaral NHS Trust, I understand are members, are we and if not, maybe we should consider joining them.	Sam Wadham-Sharpe		The issues raised by the Rural Services Network align closely with our neighbourhood and place-based approach to improving health and care outcomes in rural and coastal communities. We are not currently members of the network but will explore whether engagement could support our ongoing neighbourhood development work and wider system partnerships.			Assigned
275	13.10.26	Mo Oroko	Staff Governors	The necessary reduction in outpatient clinic space due to work on the Tower Block is in danger of squeezing already stretched consultants. If the increase in offsite clinics is not carefully coordinated, clinical time and capacity will be lost in the middle of the day travelling between sites and browsing for parking. Does the board agree this is a serious risk? If so, who will the administrative responsibility of scheduling full days on a single site reside with?	Sam Wadham-Sharpe	13.10.26	There is a robust programme of work being instigated as part of the requirements of managing any moves with five 'cells' in place to manage individual elements of the work required. The re-distribution of clinical space and the management of impacts on the workforce (including working patterns, car parking, child care etc) are both represented within the cell structure. This work will all report into the Fire Safety Oversight Group chaired by the CEO, with a monthly report to board. While no decisions have been made as of yet, it is important to note that the movement of outpatient activity away from the main hospital site is not a proposal at present.	11.11.26	23.10.26	Responded
276	21.10.26	Andrew Stilliard	Torbay	When, (target date please) will Torbay & South Devon NHSFT fully implement the nation's Supreme Court judgement on allocating separate spaces for changing and toilet facilities based upon biological sex. ' The Trust as a separate legal entity has had this responsibility since the judgment was made in Spring 2025 .	Jess Piper		chased 2.11			Assigned
277	22.10.26	Loveday Densham	Torbay	Please could clinical hospital departments ensure that a medical secretary is available to answer telephones between 9:00 am and 5:00 pm on weekdays. I have received numerous complaints from patients who are unable to contact their consultant's department regarding an issue and are instead directed to an answerphone message, which often advises them of the secretary's working hours and that their call will be returned. In many cases, this callback may not occur for several days. It was hoped that the introduction of the Epic electronic patient record system would free up more time for secretaries to undertake the vital task of communicating with patients	Sam Wadham-Sharpe		Awaiting approval			Assigned

278	22.10.26	Loveday Densham	Torbay	Carers are currently entitled to free parking at the Torbay Hospital site when the person they care for attends an outpatient appointment. Would it be possible for carers' vehicle registration numbers to be added to the parking system automatically? This would allow them to enter and leave the site without having to register their vehicle at Main Reception on each visit. This process can be particularly challenging for carers accompanying patients with mobility difficulties, as it often involves considerable walking to and from areas such as Car Park A. Introducing an automatic registration process would help reduce this additional burden and improve accessibility for both patients and	James Corrigan	22.10.26	Thank you for raising this suggestion. We recognise that registering at Main Reception on each visit can create an additional burden for carers accompanying patients. While we appreciate the benefits this could offer carers, we would not be able to introduce automatic registration for ongoing free parking. We need to be able to confirm that free parking is linked to a visit to accompany a patient, rather than being used for unrelated visits. Keeping the current checks in place helps us protect the availability of parking spaces for all patients who need them. Where the patient holds a valid Blue Badge and their carer is accompanying them, parking is already free under the existing arrangements, without the need to register at Main Reception. However, we recognise that not every patient with mobility difficulties will hold a Blue Badge. Thank you again for raising this with us	11.11.26	06.11.26	Responded
279	05.11.26	Jake O'Donovan	Teignbridge	I have been contacted by a constituent who shared a deeply concerning experience of accessing emergency care. The individual, a woman in her twenties, described experiencing a combination of symptoms including tinnitus, facial numbness, severe headaches, vomiting and visual disturbance. Having been unable to secure a GP appointment, she attended A&E, such was the severity of pain she was in.	Sam Wadham-Sharpe					Assigned
				She subsequently described feeling that her symptoms had been dismissed and that she was discharged without further investigation having allegedly been told “you can walk in a straight line, so there’s nothing unduly concerning” (I’m paraphrasing). Following a subsequent eye examination, she was referred back to Torbay Hospital and a brain tumour was identified. She is now preparing to undergo surgery.						
				I appreciate that I do not have access to the full clinical details and am not seeking a review of this individuals care. However, the experience raises an important wider question about how we recognise and assess potentially seriously neurological symptoms.What assurance can the Trust provide that patients presenting to A&E with combinations of symptoms such as severe headaches, facial numbness and visual disturbance are bring appropriately assessed, that potential neurological warning signs are recognised, and that appropriate investigation or referral takes place where clinically indicated? In particular, what processes are in place to learn from cases where a serious diagnosis is						

280	05.11.26	Jake O'Donovan	Teignbridge	A constituent recently contacted me after receiving a letter from the Trust informing them that their electronic patient record had been accessed inappropriately whilst they were receiving maternity care. The letter explained that the matter was being dealt with and that formal action was taking place in relation to the individual concerned. I have two concerns arising from this: Firstly, how widespread is this issue? Is this an isolated incident, or has the Trust identified a wider pattern of inappropriate access to patient records? What assurance can the Board provide that access is being properly monitored, that suspicious activity is identified and investigated, and that appropriate action is taken? Are there	Jamie Whaling / Nicola McMinn					Assigned
				Secondly, what support and information are being given to patients affected? Receiving a letter telling you that somebody has accessed your confidential medical records without proper authority could be deeply distressing. What information can patients expect to receive about who accessed their records, what information was viewed, and what action has been taken? How can they obtain further details or raise questions if the letter does not give them the reassurance they need?I appreciate that individual employment matters must remain confidential, but patients should be able to understand what has happened to their personal information and have confidence that the Trust is taking it seriously.							
281	05.11.26	Jake O'Donovan	Teignbridge	The Government's 10-Year Health Plan sets out an intention to remove the statutory requirement for NHS foundation trusts to have elected Councils of Governors, replacing the current model with more flexible arrangements for involving patients, staff and local communities. I appreciate that the precise timing and arrangements are dependent on legislation, but this raises some important questions about the future of public representation and accountability at the Trust. I'm keen to understand how the Trust intends to preserve meaningful public involvement and	Cath Parnell					Assigned
				What planning has the Trust undertaken for this proposed change, and does it have an emerging view of what future arrangements might look like? In particular: -How will the Trust ensure that local people continue to have a meaningful voice in decisions about he services they receive? -What arrangements might replace the current elected Governor structure, and will the public have an opportunity to shape those arrangements? -							

				How will the Trust ensure that public engagement is genuinely representative of the communities it serves, rather than simply relying on people who are already engaged or confident enough to speak up? -What will happen to the current accountability functions of Governors, including the ability to challenge the Board and hold NEDs to account? -What is the anticipated transition timetable, and how will existing Governors and the wider public be kept informed? I'm keen to understand how the Trust intends to preserve meaningful public involvement and local accountability through any changes.						

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ALL Governor Meetings 2027

- Public Board – Bimonthly (excluding August and December) starts at 12:30 pm, all meetings are held in the Boardroom, Hengrave House and via MS Teams.
- Council of Governors – Quarterly, starts at 2pm held in the Boardroom and via MS Teams
- Membership Committee – Quarterly, starts at 10am held Virtually via MS Teams
- CoG Priorities – Bimonthly, starts at 2.30pm, held in the Boardroom, Hengrave House and via MS Teams
- Governor Only – Bimonthly, starts at 2.30pm. Boardroom, but FT Office will look at visiting other Trust sites for these, at request of Governors.
- Annual Members - Once a year in September, to present the annual report.
- Governor Nominations and Remuneration Committee – Ad hoc meeting when required.

Public Board meetings - attendance voluntary at Public Session		
Date	**Time**	**Venue**
7 January	12.30 pm	Boardroom
4 March	12.30 pm	Boardroom
6 May	12.30 pm	Boardroom
1 July	12.30 pm	Boardroom
2 September	12.30 pm	Boardroom
4 November	12.30 pm	Boardroom
Governor Obligations	Governors observe NEDs contributions at Board and hold NEDs individually to account for performance of Board – (Questioning NEDs on the Trust's quality and financial performance)	

Council of Governors Meetings (4 a year)		**Dates**	**Presentation**
Chaired by	Trust Chairperson	January	
Agenda Set by	Lead Governor and Chair	10 February MS Teams only	
Governor attendance	**Statutory Attendance**	March	
Exec & NED attendance	Yes	April	
Trust Office attendance	Yes	12 May	
Time	2pm – 4pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	July	
Minutes	Required	11 August	
Description	Formal Statutory Council Meeting	September	
Purpose	Council of Governors are required to meet at least quarterly to ensure Governors can fulfil their statutory duties.	October	
Governor Obligations	Engagement with the Trust	10 November MS Teams only	
Additional Points		December	

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Membership Committee Meetings (4 a year)		Dates	Presentation
Chaired by	Membership Committee Chair	21 January	
Agenda Set by	Chair	February	
Governor attendance	**Only Governors who are on the Membership Committee attendance is required**	March	
Exec & NED attendance	No	15 April	
Trust Office attendance	Yes	May	
Time	10am – 12pm	June	
Venue	Via MS Teams	15 July	
Minutes	Required	August	
Description	Formal Committee Meeting	September	
Purpose	The purpose of the Committee is to support Governors in fulfilling their statutory duty to represent the interests of Foundation Trust Members and the public.	21 October	
Governor Obligations	Review FT membership data to target underrepresented groups	November	
Additional Points	Governors can self-nominate to join Membership committee	December	

CoG Priorities Meetings (6 a year)		Dates	Presentations
Chaired by	Trust Chairperson	19 January	
Agenda Set by	Lead Governor and Chair	February	
Governor attendance	**Voluntary Attendance**	16 March	
Exec & NED attendance	Voluntary	April	
Trust Office attendance	Yes	18 May	NED Session
Time	2.30pm – 4.30pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	20 July	
Minutes	Yes, but the format may change to best suit the meeting, which may include PowerPoint slides as a record of the meeting	August	
Description	Formal meetings	21 September	
Purpose	Meetings set aside to allow more complex priority issues to be heard and discussed by the CoG. Enabling the NED/CoG working relationship. Facilitating NEDs or Board Executives to present to the CoG in the form of a 'seminar' on key priority topics or CoG Questions. Allowing the CoG time to ask more detailed questions.	October	
Governor Obligations	Collective working and raise individual and collective questions to ensure views of FT Members and wider Public are received and responded to as required	16 November	

Additional Points	Priority sessions should where practical be linked to the Priorities set by the CoG and agreed by the Board	December	

Presentations – SIX Priorities 2027	**Date of Meeting: TBC**
	January
	March
NED Session	May
	July
	September
	November

Governor Only Meetings (6 a year)		**Dates**	**Presentations**
Chaired by	Lead Governor and deputy Lead Governor	January	
Agenda Set by	Lead Governor	16 February	
Governor attendance	**Voluntary Attendance**	March	
NED attendance	No	20 April	
Trust Office attendance	Only if requested	May	
Time	2:30 pm to 4:30 pm Summer 4.15 pm – 6.15pm	15 June	
Venue	Boardroom, Hengrave House	July	
Minutes	As required, which may include a bulleted summary of the meeting or no minutes at all under the Chatham House Rule	17 August	
Description	Informal Governor **only** meetings	September	
Purpose	Regular Governor only meetings to ensure Governors can discuss and debate all relevant issues to ensure a level of collective knowledge and responsibility. The agenda may include Governor training as CPD, and reports by Governor Observers, CoG Committees and Constituency leads.	19 October	
Governor Obligations	Enables collective working	November	
Additional Points	Can be held in community settings if requested.	21 December	

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Annual Members' Meeting (1 a year)		Dates
Chaired by	Trust Chairperson	January
Agenda Set by	Membership Committee, Lead Governor, and Chair	February
Governor attendance	**Voluntary or as requested to support**	March
NED attendance	Voluntary or as requested to support	April
Trust Office attendance	Yes	May
Time	TBC	June
Venue	TREC Lecture Theatre, next to Horizon Centre, Torbay Hospital	July
Minutes	Required	August
Description	Statutory Annual Members' Meeting to receive annual report, quality report and accounts.	22 September
Purpose	To present to members: and the public the annual accounts and report. Including any updates on membership and Governor elections.	October
Governor Obligations	Representing FT Members and Public and Hold NEDS collectively to account for performance of Board	November
Additional Points		December

Chair and Lead Governor Meetings		Dates
Chaired by	Trust Chairperson	January
Agenda Set by	Chair and Lead Governor	February
Governor attendance	**Bimonthly Lead Governor and Constituency Leads. Trust CEO may also attend if available.**	March
NED attendance	No	April
Trust Office attendance	No	May
Time	As diary permits – Chair PA arranges meetings	June
Venue	Chair's Office, Hengrave House	July
Minutes	Bulleted highlights produced for CoG	August
Description	Informal meeting	September
Purpose	Regular meetings between the Chair and the LG/DLG. Providing an informal meeting where issues or questions emanating from the Governor meetings can be discussed directly with the Chair.	October
Additional Points		November
		December

Constituency Meetings		Dates
Chaired by	Nominated Governor in each constituency	January
Agenda Set by	Constituency Governors	February
Governor attendance	**All Constituency Governors as available**	March
NED attendance	If invited	April
Trust Office attendance	No	May
Time	As diary permits	June
Venue	Local	July
Minutes	As required, which may be bulleted highlights produced for reference	August

Description	Informal meeting	September
Purpose	To enable Governors specific time to focus time on local constituency related issues	October
		November
Additional Points	Normally held quarterly	December

Governor Observer Reports from the Board Level Sub Committee Meetings		**Dates**	**Committee (Governor Initials)**
Observed by	Nominated Governor for each Committee	January 22 28 27	 Audit and Risk (ARC) (AR) Finance and Operations (FOC) (DC) Quality and People (QPC)(VB)
Governor attendance	**Nominated Governors as available**	February 24 25	 QP (VB) FOC (DC)
Report	Circulated via monthly email to all Governors and available in MS Teams channel	March 4 24 25	Charitable Funds Committee (CFC) (LD) QPC (VB) FOC (DC)
Description	Observations	April 28 29 30	 QPC (VB) FOC (DC) AR (AR)
Purpose	Assessing the NEDs performance	May 26 27 28	 QPC (AP) FOC (DC) ARC (VW)
Additional Points	New Governor observers decided to start in May.	June 17 23 24 25	 CFC (MJ) QPC FOC ARC
Governor Obligations	Hold NEDs individually to account for performance at each Committee	July 28 29 30	 QPC FOC ARC
		August 25 26	 QPC FOC
		September 22 26	 QPR FOC
		October 27 28 29	 QPR FOC ARC
		November 24	 QPR

		25	FOC
		December 9 15 23	 CFC QPR FOC

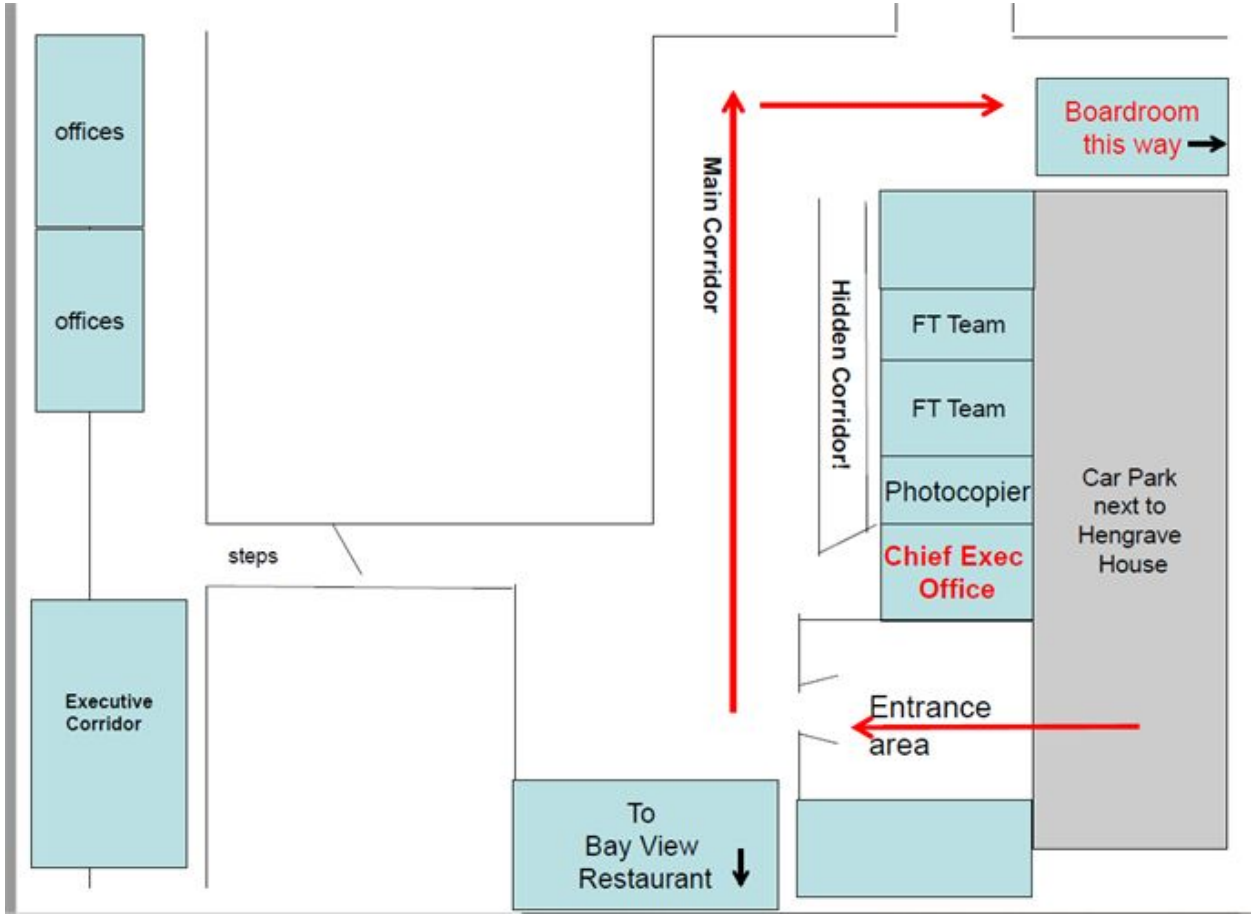
Governor Nominations and Remuneration Committee (AD HOC)		Dates
Chaired by	Trust Chairperson	Held as required
Agenda Set by	Chair	
Governor attendance	**Governor Members Only**	
NED attendance	Senior Independent Director	
Trust Office attendance	Corporate Governance Manager	
Purpose	Involvement input for performance appraisals for Chair and NEDs	
Governor obligations	Hold NEDs individually to account for performance of Board	
Additional Points		

Summary of standing and ongoing Governor Obligations:

- Ask about CQC judgements on the quality of care at the Trust – ad hoc
- Contact Senior Independent Director – if have concerns or if direct contact is inappropriate – ad hoc
- Jointly approve amendments to Trust's constitution – ad hoc
- Approve any "significant transactions" and approve a merger, acquisition, separation or dissolution – ad hoc as required
- Appoint and, if appropriate remove the Chair. Appoint and, if appropriate remove the NEDs – ad hoc, as required
- Appoint and if appropriate remove the Trust's external auditor – ad hoc, as required
- Approve the appointment of the Chief Executive – ad hoc as required
- Decide whether the Trust's non-NHS work would significantly interfere with its purpose – ad hoc as required.
- Have their views taken account of when Trust sets its strategy.
- PLACE Assessments (October 2024) Ensure views of public are added into the annual PLACE Assessments

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MAP TO LOCATE BOARDROOM WITHIN HENGRAVE HOUSE, TORBAY HOSPITAL, TQ2 7AA



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Audit & Risk Committee
Governor Observer Report for meeting dated 29th October 2026

Governor Observers are asked to consider the following questions:	
Question	**Comment**
Was the meeting well chaired?	Yes, MG brought the meeting back if it drifted and was conscious of time, finishing 30mins earlier than anticipated.
Were members engaged throughout the whole meeting including contributions by NEDs?	Yes, Lots of contribution from NEDs, both Committee chairs & 'new' NEDs.
Did the meeting discuss key risks\issues, or did you see a risk register?	It discussed Risk at length, we saw the BAF& CRR.
If there was an action log, was this discussed and updated?	Yes, both discussed & updated.
Was there anything that concerned you about the governance of the meeting? If yes, please detail.	No, nothing.
Key issues to be escalated to the CoG which could be included as an item for discussion at a future Governor meeting.	Nothing to be escalated.
Key issues to be escalated to the Board.	Risk Appetite understanding – escalated with the view of discussing at Board Development.

Report completed by: Vicki Payne-Cater

Date: 2nd November 2026

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Finance and Operations Committee
Governor Observer Report for meeting dated 23/09/2026

Governor Observers are asked to consider the following questions:	
Question	**Comment**
Was the meeting well chaired?	Always. The chair also prefaces any action within the pack with what the committee members are looking for as an answer. Chair reassuring members with support.
Were members engaged throughout the whole meeting including contributions by NEDs?	Yes, they were appropriately challenging the Operations Officer regarding current challenges within the Emergency Departments and raising questions about the underlying challenges and scrutinising the improvement and action plans. The NEDS discussed between themselves about the risk and assurance levels and had a healthy discussion which brought them to the same decision ultimately and worked together to create an outcome that everyone had agreed on, to springboard to the next meeting where they will assess the levels. The NEDS work together well to discuss and scrutinise what is being presented. The newer NEDS are very engaged with the conversation and discussion.
Did the meeting discuss key risks\issues, or did you see a risk register?	
If there was an action log, was this discussed and updated?	The action log was discussed and closed and updated as appropriate. A good level of detail on the progression of the action log from committee members.

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Was there anything that concerned you about the governance of the meeting? If yes, please detail.	No
Key issues to be escalated to the CoG which could be included as an item for discussion at a future Governor meeting.	Change involving emergency care at both Torbay Hospital as well as the Urgent Treatment Centre at Newton Abbot and improvement noted already which should provide some reassurance for the constituencies, that Torbay are working hard at trying to improve this.
Key issues to be escalated to the Board.	How will IHCS data be archived and will pathway information be available to staff as this is still pertinent for legacy patients? How can improvement in productivity happen if the clinical staff have non-working weeks, which will increase reduced capacity?

Report completed by: Olivia Bath

Date: 23/09/2026