Torbay and South Devon NHS Foundation Trust
Public Board of Directors

The Boardroom, Hengrave House/MS Teams

25 May 2022 11:30 - 25 May 2022 14:30

AGENDA

#	Description	Owner	Time
1	Welcome and Introductions Note	Ch	11:30-11:35
2	Preliminary Matters	Ch	
2.1	Apologies for Absence and Quoracy Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Board Corporate Objectives Information 2.03 Board Corporate Objectives.pdf 9	Ch	
3	Celebrating International Partnerships Note	CN	11:35-12:00
4	Consent Agenda (Pre Notified Questions)		
4.1	Committee Reports		
4.1.1	Finance Performance and Digital Committee Chair's Report - 25 April 2022 Note 4.01.01 Finance Performance and Digital Committe... 11	P Richards	
4.1.2	Quality Assurance Committee Chair's Report - 28 March 2022 Note 4.01.02 Quality Assurance Committee Chair's Repo... 15	J Lyttle	
4.1.3	People Committee Chair's Report - 25 April 2022 Note 4.01.03 People Committee Chair's Report - 25 April... 21	V Matthews	

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4.1.4	Audit Committee Chair's Report - 20 April 2022 Note 4.01.04 Audit Committee Chair's Report - 20 April 2... 23	S Taylor	
4.1.5	Building a Brighter Future Chair's Report - 18 May 2022 Note 4.01.05 Building a Brighter Future Chair's Report -... 25	C Balch	
4.1.6	Committee Annual Reports - Quality Assurance Committee, Finance Performance Digital Committee, People Committee, Building a Brighter Future Committee, Audit Committee Receive and Note 4.01.06 QAC Annual Report 2021-22.pdf 27 4.01.06 FPDC Annual Report 21-22.pdf 33 4.01.06 People Committee Annual Report 21-22.pd... 39 4.01.06 BBF Committee Annual Report 21-22.pdf 45 4.01.06 Audit Committee Annual Report 21-22.pdf 51	IDCG	
4.2	Reports from Executive Directors (for noting)		
4.2.1	Chief Operating Officer's Report - April 2022 Receive and Note 4.02.01Chief Operating Officer's Report - April 2022... 59	COO	
4.2.2	Director of Transformation and Partnerships Quarterly Update Receive and Note 4.02.02 Directorate of Transformation and Partners... 71	DTP	
4.2.3	Estates Performance and Compliance Group Report Receive and Note 4.02.03 Estates Performance and Compliance Grou... 77	CFO	
5	For Approval		

#	Description	Owner	Time
5.1	**Unconfirmed Minutes of the Meeting held on the 27 April 2022 and Outstanding Actions** Approve 5.01 Unconfirmed Minutes of the meeting held on th... 85	Ch	12:00-12:05
6	**For Noting**		
6.1	**Parking Lot of Deferred Items** For Information 6.01 Parking Lot of Deferred Items.pdf 97	DCG	
6.2	**Report of the Chairman** Verbal	Ch	12:05-12:15
6.3	**Chief Executive's Report** Receive and Note 6.03 Chief Executive's Report.pdf 99	CE	12:15-12:30
7	**Safe Quality Care and Best Experience**		
7.1	**Integrated Performance Report (IPR): Month 1 2022/23 (April 2022 data)** Receive and Note 7.01 Intergrated Performance Report Month 1 2022... 119	MD	12:30-12:45
7.2	**Mortality Safety Scorecard** Receive and Note 7.02 Mortality Safety Scorecard.pdf 189	MD	12:45-13:00
7.3	**CQC Annual Assurance Report** Receive and Note 7.03 CQC Annual Assurance Report.pdf 209	CN	13:00-13:15
8	**Valuing our Workforce**		
8.1	**Freedom to Speak Up Guardian Six Monthly Report** Receive and Note 8.01 Freedom to Speak Up Guardian Six Monthly R... 223	CPO	13:15-13:30

#	Description	Owner	Time
9	Improved Well-Being Through Partnerships		
10	Well-Led		
10.1	Refresh of the Trust Constitution Approve 10.01 Refresh of the Trust Constitution.pdf 229	IDCG	13:30-13:45
11	Compliance Issues		
12	Any Other Business Notified in Advance Note	Ch	
13	Date and Time of Next Meeting - 11.30 am, Wednesday 29 June 2022 Note	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

1. Safe, quality care and best experience
2. Improved wellbeing through partnership
3. Valuing our workforce
4. Well led

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems.
2. Failure to achieve key performance / quality standards.
3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision.
4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.
5. Failure to achieve financial plan.
6. Care Quality Commission's rating of 'good' and the ability to maintain sufficient progress to retain 'good' and achieve 'outstanding'.

Torbay and South Devon NHS Foundation Trust

Report of Finance, Performance and Digital Committee Chair to the Board of Directors

Committee meeting date:	25 April 2022
Report author + date:	Paul Richards, Non-Executive Director 20 May 2022
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issues to highlight to the Board

The Committee received the BAF and CRR and noted the highlights and changes. It was agreed that it would be helpful for the Trust to compare the its risk ratings with others in the system to gain an understanding around how it compared to other organisations. The committee also discussed the definition of financial sustainability, and would reflect this in its future deliberations as to the financial outlook.

Investment

Performance

The Committee received the M12 integrated performance report and noted the following points.

The Trust had been treating up to a maximum of 71 patients with Covid during March. This number had now reduced to 17 patients on one ward. Recovery planning continued, and as well as the Day Surgery Unit and Medical Receiving Unit now fully functioning, Ella Rowcroft ward was supporting elective care.

Nevertheless, capacity constraints in domiciliary care and the care home market continued, affecting flow into the community, and Opel 4 had been declared on 18 days in March. 702 patients had spent 12 hours or more in the Emergency Department and over 1,026 patients had waited over 30 minutes for an ambulance handover. 246 patients had now waited over 104 weeks for treatment, but it was expected that this figure would start to reduce now that the Day Surgery Unit and Ella Rowcroft Ward were fully operational. Concern was raised around Urology performance. It was noted the service was moving to a new location as an interim solution, but a long term solution did need to be identified for the service.

The Committee also noted the improvements to cancer and two week wait performance.

The Committee reviewed the Month 12 financial performance, reporting an end of year adverse variance of £59,000 against its target to deliver a surplus of £1.8m. This included a negative impact in Month 12 of £200,000 relating to a write back of capital to revenue for unitary payments related to the Newton Abbot Hospital private financial initiative. The Capital target for year-end had almost been met.

Short term planning

The committee received a paper on the budget setting exercise for 2022/23. The financial plan had been improved and a deficit of £29.9m was presented (compared to the original figure of £32.7m). The committee discussed the changes that had been made to reach the revised deficit figure. Key risks were noted, including activity assumptions and the requirement to meet 104% of historic activity levels, the allocation and flow of elective recovery funding, the delivery of an ambitious cost improvement target. Detail on the Trust's capital plan were also summarised.

The Committee noted that there was a need for system working to ensure capacity across the system was fully utilised. The need for all system partners to play their part and be held accountable was noted. The committee also questions the approach to grip and control on the Trust's financial position. The CFO highlighted the work taking place to recruit to vacant posts which would then reduce the Trust's reliance on agency and bank staff and that Deloitte's work continued at pace on the Financial Improvement Programme.

The Committee also received a detailed report on capital planning, noting the following points. In 2021/22 £37.6m of capital had been spent against a target of £39m. The slippage had been used to support schemes in other parts of the system. Torbay Pharmaceuticals reported £1m of unanticipated slippage against their capital programme which would impact on their capital sum for 2022/23.

Looking ahead, the Trust had been allocated £18.4m of ICS Capital Departmental Expenditure Limit (CDEL) funding for 2022/23 and £19.3m national CDEL, however this was still subject to approval. Seed funding allocation for the Building a Brighter Future Programme was less than that required; and business cases had been made for protected elective capacity and digital. It was hoped £7m of digital levelling up funding would be received.

Potential mitigations were discussed, focusing mainly on IFRS16 transitional relief which should be available to absorb the impact of existing operating leases coming 'on balance sheet'.

Taking the above into account, the Trust was carrying a forward capital commitment of c£23m. Plans were in the process of being validated and quality impact assessments undertaken. The output of this work would be taken to the Capital Investment Delivery Group (CIDG) and then Finance Committee at the end of June.

Other matters.

The Committee also received the following items:

- Update on Patient Centred Outpatients
- Update on GIRFT delivery
- Quarterly Treasury Performance report
- Commercial pipeline report
- Subsidiary and sub-committee reports

Key decisions/recommendations made by the Committee

Approved:

- To recommend to Trust Board the revenue and capital budget plans for 2022-23

Escalating:

- Concern around progress against the GIRFT programme of work and the need for a multi-disciplinary approach. Concern that this may drive risk and cost.
- Lack of progress at ICS level to realise the level of change needing to enable the Trust to meet its targets
- The need for the Trust to ensure that, rather than having lots of initiatives in place to transform services, one coherent plan of work should be progressed with focus.
- The need to monitor performance against the 104% target in order to meet budgeted income.

Quality Assurance Committee
Chair's Report to the Board of Directors

Meeting date:	28th March 2022
Report by and date:	Jacqui Lyttle Committee Chair 18th May 2022
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 discussed and decisions made:

The committee covered a broad agenda but would like to bring the following specific items to the board's attention

1.Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

The committee received and noted the BAF and CRR relating to quality, safety, and risk. It received assurance that no significant changes had been made to the BAF since the last meeting in January. It also noted that actions were still ongoing as a result of the CQC inspection in December, and it was agreed that a detailed update would be provided at the next meeting.

2. Deep dive service review - Ophthalmology Deep Dive (BAF Objectives 2 and 4)

The committee received a detailed presentation detailing the background, historical and current drivers to the increasing number of waits in Ophthalmology and the impact on patients. The committee noted the following:

- Backlog of 9,000 patients.
- Annual demand equated to 13,500 new patients and the need for 64,000 follow up appointments.
- The clinical space was considered at capacity in 2012.
- There had not been an increase in staff following NICE approval of Lucentis injections in 2006 for macular degeneration.
  A recent review had analysed 11 reported incidents and identified two main themes – administrative errors and delayed follow ups.

Whilst the committee were assured that urgent remedial action had taken place as a consequence of the review it was not assured that adequate controls and processes were in place to ensure that patients were properly prioritised and to reduce harm on a systematic or business as usual basis.

3. Staff Staffing Bi-Annual Review (August 2021 – January 2022) (BAF Objectives 2 a

The Committee received and noted the Safe Staffing Bi-Annual Review, in particular the increasing challenges to delivery of staffer staffing due to Covid-19; received assurance that staff staffing levels had been maintained over the last six months; and the mitigation and action plans in place.

4. Liberty Protection Safeguards (LPS) (BAF Objectives 2 and 4)

The committee received a very comprehensive report and noted the following risks and mitigating actions

- New statutory duties under the Mental Capacity Amendment Act 2019 were likely to come into force in either April or October 2023.
- The duties applied to all of the Trust's services and for all patients over the age of 16.
- It was estimated it would affect c4,000 patients a year, most of whom would be in NHS hospital settings.
- The Trust would need to appoint a number of staff to ensure it could meet the new legal duties and it would be in competition with other local providers to find suitable staff.
- An implementation plan was in place and it was noted that, at present, no budget had been identified to support the need for additional staff, new systems or office space. Funding would be discussed at the Finance, Performance and Digital Committee in April. It was agreed an update report would be provided to the Committee following the April meeting. ACTION: JA
- It was noted that the staff required would need to hold professional qualifications and registration and it was suggested the Trust could advertise for the posts at risk, whilst the funding source was in the process of being identified.

The Committee received and noted the Liberty Protection Safeguards Report.

5. Improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Surveys for 2021, NHS Maternity Survey (BAF Objectives 2, 4 and 10)

The Committee received and noted the NHS Maternity Survey Report. It was pleased to note that the Trust was not an outlier compared to other Trusts across England.

The Committee was also assured by the results of the survey, and overall feedback noting those areas that required improvement.

6. Care Quality Commission NHS Children and Young People's Patient Experience Surveys 2020 Reports (BAF Objectives 2, 4 and 10)

The Committee received and noted the report. Key points covered in details included:

- The Trust was above average in respect of the involvement of families in decision-making and care planning; no changes to discharge dates; and availability of Wi-Fi.
- The need for improvements to be made to space for play and activities; ward suitability; staff awareness of medical history; and noise at night. These were areas

for improvement that the Trust had previously identified, some of which were as a result of the infection prevention and control measures put in place due to Covid.

The Committee welcomed the report and felt that it was very positive.

7. Maternity Governance Update (BAF Objectives 2, 4 and 10)

The committee received a very comprehensive update with particular attention being drawn to the following issues and risks:

- The Trust would not be able to demonstrate compliance with the Clinical Negligence Scheme for Trusts (CNST) standards due to performance related to carbon monoxide monitoring for expectant mothers. Monitoring usually took place at 12 and 26 weeks and Trusts were required to evidence 80% compliance. Non-compliance was due to a reduction in face to face meetings due to Covid and a reluctance from mothers to do the test as it was aerosol generating. All Trusts were in the same position and were awaiting guidance from the CNST around how they would manage this issue.
- Progress continued towards achievement of the Continuity of Care model and a paper would be presented to the next meeting on this issue. The Trust currently provided 62% continuity of care during the antenatal period and 28% during labour. The need to implement the model had resulted in a negative impact on teams and work was taking place to provide a flexible solution for staff.
- The Committee noted that there was a financial implication the Trust if it did not meet the CNST requirements, alongside a reputational issue and compliance with the Ockenden requirements.

The Committee received and noted the Maternity Governance Update report.

8. Health Quality Report (BAF Objectives 2 and 4)

The committee received and noted the Health Quality Report. The report covered a number of service and performance metrics but would like to bring the following to the boards attention:

- Only 2.9% of stroke patients had been admitted to a stroke ward within four hours during February. This was due to bed availability on the stroke ward and delays in the Emergency Department (ED).
- 59% of patients were treated on the stroke ward. Any stroke patients located in ED were reviewed on a daily basis to ensure there were no delays to their treatment. In addition the stroke team provided an outreach service to ensure stroke patients on other wards received the treatment they required.
- Venous Thromboembolism (VTE) performance had improved in February to 95.2%.
- Since December, and in line with recommendations as a result of the Ockenden Review, maternity metrics were now reported in line with the Robson Group categories, which classed deliveries into one of ten groups and with a risk classification.
- The Hospital Standardised Mortality Rate date was below the expected level of 100 in November, however the rolling 12 months was above 100 at 108. Over the past 12 months there had been an increase to 110 in the summer months and reduction in the autumn.

- The Standardised Hospital Mortality Index data also showed a risk in mortality in the summer months, which it was thought was related to the pandemic and work was taking place to clarify this assumption.
- Work continued to action the recommendations from the CQC following their visit in December 2021, in particular around nutrition and hydration.
- Harm reviews were undertaken for all patients who were waiting in ED longer than 12 hours with the reasons for these delays detailed in the report. They included bed allocated before four hours but not ready; no side room available; await porter to move patient; and too sick to move.
- There had been 19 Strategic Executive Information System (STEIS) incidents in January and February, 13 of which were related to slips, trips and falls.
- Work concluded to close down incidents within the target of 28 days, with the current backlog reducing.
- The Patient Safety Team had undertaken a review of serious incident aggregated reviews, for example in Ophthalmology, to help support learning and understanding.
- Due to the large number of similar incidents that had occurred in Ophthalmology, agreement was sought form Devon CCG to undertake a single overarching aggregate review of the incidents, each of which would have required a separate review.
- In respect of nutritional risk assessment data, daily audits had been implemented which provided continuous information of over 2,000 patients a month, compared to the point of prevalence audit that had been in place, which only audited 350 patients once a month.

The Committee received and noted the Health Quality Report, being assured that adequate controls are in place to monitor and mitigate harm, and action plans are in place for remedial recovery in areas of specific high clinical risk such as ophthalmology, ED, long waiters and stroke.

9. Adult Social Care Report (BAF Objectives 2 and 4)

The committee received its first detailed Social Care Quality Report and noted the following:

- The improvements to the reporting structure that had been put in place.
- The Trust was scoring green and amber for most of the targets on the Adult Social Care Outcome Framework, with some work taking place around direct payments, currently scored red.
- It had been identified there were lower numbers than expected of Mental Capacity Act activity, so a deep dive was taking place to ascertain if the data was correct.
- There continued to be a large Deprivation of Liberty backlog. There was a shortfall in the workforce with only one best interest assessor in post against an establishment of three. Work was waking place to try to recruit to the vacant positions however there was a national shortfall of best interest assessors. In addition, there was a lack of suitable placements for clients. Work was taking place to try to shape the market for the future, but it would take some time to realise any changes.
- It was noted the Torbay area comprised small community care homes, and many of them had closed over the past few years resulting in a significant reduction of beds in the community. There was a need for the Trust to drive the market and levers to ensure the market was fit for the future.
- Areas of improvement included data collection; legal literacy; and single point of contact.

- The service carried a backlog of 43 individuals who required a complex care assessment. It was hoped this would start to reduce as staffing capacity increased following annual leave.
- The team was now co-located with the community Mental Health team which was making joined up working much easier.

The Committee received and noted the Adult Social Care Report in particular it was assured by the governance arrangements in place for oversight of adult social care improvement plans; areas of concern; mitigations and actions.

Key Decisions/Recommendations Made:

1. The committee chair agreed to escalate the increased risk to patients coming to harm due to excessive backlogs, mismatch in capacity and demand and patient being lost to follow up to the Board as an increased risk, and asks that further work be undertaken to review the service from a patient safety and quality perspective.
2. On receiving the Maternity Governance Update report, the committee ask the board to note that is had considered the following
   - timescales for completion of the Maternity Self- Assessment Tool;
   - current underperformance in CO2 monitoring and actions to strengthen mother and baby safety.
   - risks to attached to CNST Level 4 attainment
   - challenges with achieving Continuity of Carer at scale and actions being taken to recruit to and ensure the model was fully adopted.
3. No other risks were identified to bring to the board's attention

Torbay and South Devon NHS
NHS Foundation Trust

Report of the People Committee Chair to the Board of Directors

Meeting date:	25th April 2022
Report by:	Vikki Matthews
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☒ 4: Well led ☐
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☒ or Private ☐

The items and risks to be raised to the Board are as follows:

1. Staff Survey Results

- The staff survey results were shared and the Committee were pleased to note improvements in some areas, with the Trust being above the national average for: people not looking for jobs in new organisations; able to make suggestions on improvements; good work/home balance; showing appreciation for each other; and having a choice on how to do their work.
- Appraisals continued to be an area of concern, both for staff who had not received one or where it was felt the process was not adequate and we will need to monitor whether the newly designed process will help to address the latter concern.
- It was disappointing to note, despite the amount of work that had taken place on the Trust's wellbeing offer to staff, that this was not reflected in the survey results. It showed there was still more work to do to improve the Trust's offer and to ensure that the offer is accessible.
- It was also disappointing to note that bullying and harassment remained a concern for staff.
- The Committee acknowledged the good work that has gone to address some of these areas and advised that it would be preferable to focus on a few high impact initiatives that can be embedded in to the organisation rather than spread the available resource too widely and not get the traction desired.

2. Freedom to Speak up Report

- Sarah Burns presented the Freedom to Speak Up Bi-Annual Report. The themes covered in the report were the same as those reported to previous meetings, specifically bullying and harassment and patient safety.
- The Committee noted the cultural dimension to this work and how the delivery of Just and Learning Culture and leadership training could positively impact on the areas of

concern. The Committee commended the work of Sarah and her team as a critical tenet of the Trust's ambitions to ensure psychological safety for all.

3. Workforce planning and strategy

- The Committee discussed the area of workforce planning and retention. Of particular focus was determining what work the Trust should be attending to locally and what should be picked up as part of the ICS workforce strategy. The Committee asked that there should be a local focus on retention and an analysis of risk in relation to turnover in clinical and non clinical areas.
- Mark Sowden joined the meeting to share the ICS workforce strategy which is currently in phase 3 of its 7 stages. He reported that activity is expected to increase by 2.9% over the next seven years requiring an additional 15,000 staff by 2030 across the system, which was unsustainable. The Strategy would aim to look at how the system could work differently to deliver the expected increase in demand whilst delivering a financially sustainable and robust staffing model and was commended by the Committee with an ask for assurance that the work aligns with the Trust's Building a Brighter Future Strategy.

4. Staff absence

As has been highlighted in previous reports, the Committee remain concerned about the rising level of staff sickness which was reported for March at 5.34%, the highest monthly figure on record.

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

1. The Committee asked that a strategic overview of the work on short, medium and longer term workforce planning be brought to the Committee with a view on what work should be undertaken locally and what should be done at a system level.

Torbay and South Devon NHS Foundation Trust

Audit Committee
Chair's Report to the Board of Directors

Meeting date:	20/04/22
Report by:	Sally Taylor
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 Board:

1. Internal Audit reported on a review of the EPMA project which was stopped after approximately 9 years. Lessons learned included: the need to hit benefits early on in the project, the need for realism, the need for clinical advisory groups to be consistently engaged throughout and the need for IT resource to support the project.

2. The committee received the Internal Audit plan and requested some days to be available for the new CPO once they have identified priority areas. Four completed audits were presented. Three were satisfactory but the report on Payroll only provided limited assurance due to management of overpayments.

3. The Board Assurance Framework was reviewed. It was noted that there is a refresh due to ensure it reflects the new Trust strategy. It was suggested that the revised BAF should reflect the three categories of risk the Trust experiences. That is: those the Trust can address locally, those that are system level risks and those that relate to national policy and direction where the Trust does not have freedom of action.

4. Counter Fraud report was received. Noted that the Counter Fraud Authority recently imposed new functional standards. Most areas now assessed as green. 2 amber rated areas should be green for the next submission.

5. Updated policies were reviewed and approved in respect of : Standards of Business Conduct, Conflicts of Interest and Counter Fraud – Bribery and Corruption.

6. Tender waivers were presented. The value has increased from the previous period and is considered to be too high. Reasons include the year end capital plan, the late receipt of capital monies from the centre, funding received for sustainability and restoration, contracts re IT outages, equipment maintenance and software which would have disrupted service delivery if not renewed, items sourced through a national supply chain that has already been subject to procurement and annual renewals treated as one-offs, Deloitte will be reviewing processes to ensure appropriate procurement is in place.

7. The losses and special payments report was received and the growing level of Adult Social Care debt was noted with concern. Some of the increase may be attributable to Covid delaying house sales and the Council's legal team prioritising other areas. This will be followed up with the Council.
Key decision(s)/recommendations made by the Committee: **See above**

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Building a Brighter Future Committee
Chair's Report to the Board of Directors

Meeting date:	16th May 2022
Report by:	Chris Balch
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 Board (May 2022):

1. The Committee discussed the updated programme risk report and considered further revisions to and updating of the BAF particularly in respect of Objective 11. These seek to reflect where the responsibility for managing the risk lies. In many cases this is external to the Trust, for example at system and national level. It was agreed that the focus of the Committee should be on managing the risks which are in the control of the Trust and ensuring that linkages are made to other areas of the BAF e.g., Objective 1.

2. The Committee received a Level 1 project timetable as recommended by the recent state of readiness review. Given the uncertainties which exist regarding the timing and nature of the approval processes 3 scenarios were presented reflecting an optimistic, realistic and pessimistic assessment of likely progress. It was agreed that the optimistic assessment which envisaged substantive construction commencing in January 2025 now appears unlikely. The realistic scenario now envisages a start in September 2025 while the pessimistic scenario could be a year later. The Committee noted the importance of the Trust being able to commence site enabling works in January 2023. Additional seed funding is being sought from the NHP to enable the preparation of a business case for enabling work to proceed. This will follow a re-submission of the SOC once sources of funding for the digital investment are clarified. This is expected by the end of June 2022.

3. The Committee discussed the importance of ensuring that capital investment in estates facilities over the next few years should maintain the bridge to the 'brighter future' and noted the need for close co-ordination between the work of the BBF and FPDC Committees to ensure alignment.

4. The Committee received a report indicating good progress with the processing of the Digital OBC. The Trust continues to pursue a twin track approach ensuring that the ambition of a Peninsula-wide EPR remains achievable. Work continues to

prepare tender documentation enabling the Trust to identify a preferred EPR provider once our OBC is approved.

5. The Committee were assured that the clinical engagement needed to design and deliver the Trust's Care Model is now underway with Drumbeat sessions generating significant energy and enthusiasm from clinical teams. Consideration is being given to the future role of Design Leaders where activity may be impacted by resource constraints. The Committee received an update on the wider engagement and communication activities related to the BBF Programme, including a report on the results of the recent roadshow.

6. The Committee received two deep dives into the risks associated with the delivery of efficiencies from the provision of shared services and the cost of data migration required as part of the implementation of an EPR. While significant uncertainties remain at this stage of the programme, the Committee were assured that both risks are 'on the radar' and appropriate arrangements are/will be made to mitigate them.

7. The Committee received an update on the monthly cohort 4 meeting which now takes place with the NHP team and heard from the Trust's Project Sponsor. This provided assurance that the challenges facing the Trust over the delivery of the BBF programme are understood and recognised at a national and that efforts are being made to resolve both funding and process issues in the near term.

8. The Committee received a month 1 funding report which highlighted that the current allocation of seed funding represents a 'stand still' position. However further allocations are being sought which will enable priority work on the SOC and the Site Enabling business case to proceed.

1) To note the above

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NHS Foundation Trust

QUALITY AND ASSURANCE COMMITTEE

ANNUAL REPORT

2021/22

1. INTRODUCTION

1.1 The Quality and Assurance Committee (the 'Committee'), in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 This report covers the work the Committee has undertaken at the meetings held during 2021/22. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

1.3 The Committee has powers delegated to it by the Board to:

(i) review proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account;

(ii) seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified; and

(iii) oversee the ongoing monitoring of compliance with national quality standards and local requirements.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to:

(i) provide assurance to the Board that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care; and

(ii) ensure that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

1.5 The Committee Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes the Head of Patient Safety, System Directors of Nursing and Professional Practice, and others who may be required to attend as necessary such as the Safeguarding Adults Lead, Deputy Director of Adult Social Care, Head of Tissue Viability Services, Associate Director of Midwifery and Professional Practice etc.

2.1.2 Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation, specialist areas of expertise, attending Board of Directors and Council of Governors meetings. The practice of visiting services and talking to staff was however restricted during the year due to the Covid pandemic and the government guidelines that were imposed for the period of this report.

2.1.3 The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

2.1.4 Compliance with a number of the key responsibilities is evidenced by the following areas of work the Committee has received assurance on during 2021/22.

2.2 Quality and Improvement

2.2.1 Monitoring and reviewing the quality of clinical and social care services provided by the Trust. This included review of:

(i) the systems in place to ensure the delivery of safe, high quality, person-centred care;

(ii) quality indicators flagged as 'of concern' through escalation reporting or as requested by the Trust Board;

(iii) an action log evidencing progress toward completion; and

(iv) progress toward delivery of the Trust's clinical strategy.

2.2.2 Reviewing variances against quality and operational performance standards.

2.2.4 Ensuring there is a robust Quality and Equality Impact Assessment process to mitigate any adverse impact of service changes or reconfiguration.

2.2.5 Reviewing the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding process with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

2.2.6 Receiving, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

2.2.7 Overseeing the development of the Quality Account regarding accuracy of data and compliance with timescales for publication and review progress against these.

2.2.8 Establishing, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessment, standards or criteria.

2.2.9 Ensuring the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the quality of care.

2.3 Governance and Risk

2.3.1 Overseeing how all quality risks are managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the corporate risk register and Board Assurance Framework.

2.3.2 Promoting an open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

2.3.3 Seeking assurance on the process for reviewing and reporting complaints, adverse events and serious incidents and sharing the learning from these.

2.3.4 Seeking assurance against compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance.

2.3.5 Overseeing any procedural, policy or strategy document which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with any key national standards and best practice.

2.3.6 Establishing an annual work plan which the Committee will review at each meeting.

2.3.7 Producing an annual report against delivery of the terms of reference of the committee.

2.3.8 Undertaking an annual review of the Committee's effectiveness

2.4 Quality and Safety Reporting

2.4.1 Receiving reports from each of the Committee's sub-groups.

2.4.2 Receiving and review submissions to national bodies and make recommendations for sign-off by the Trust Board.

2.4.3 Receiving annual assurance reports in relation to (but not limited to) infection control and safeguarding and medicines management.

2.5 Audit and Assurance

2.5.1 Receiving and review the findings of quality related Internal Audit reports and seek assurance that recommendations are implemented in a timely and effective way.

2.5.2 Approving and oversee delivery of the Clinical Audit Plan and provide assurance to the Audit Committee of delivery.

2.5.3 Receiving by exception information of national clinical audits where the Trust is identified as an outlier or a potential outlier.

2.5.4 Receiving reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions.

2.5.5 Receiving reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken.

2.6 Reporting Requirements

2.6.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.6.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF') in relation to those risks within the scope of the Committee.

3.2 The Committee review of the BAF focussed on quality and safety related risks. Deep-dives in to specific risks were commissioned on a risk-based approach and were as follows:

- CFHD Service Review- Autism Spectrum Disorder Diagnostic Pathway
- Safety Framework – ED and 12 hour breaches
- Stroke Services
- Social Care Placements Quality Assurance
- Quality Assurance Framework for Independent Providers
- Ophthalmology Service

4. MEMBERS AND MEETINGS

4.1 During 2021/22, the Committee met on a bi-monthly basis. The meetings were quorate all times.

4.2 The record of Committee attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Jacqui Lyttle (Chair)	6 (6)
Vikki Matthews	6 (6)
Jon Welch (retired 30.09.2021)	1 (3)
Sarah Wollaston (in post 01.10.21 to 29.11.21	0 (1)
Executive Directors	**Number of meetings attended**
Ian Currie	4 (6)
Judy Falcao	3 (6)
John Harrison	5 (6)
Deborah Kelly	6 (6)

4.3 Senior management representatives also in regular attendance included the Director of Corporate Governance and Trust Secretary and Corporate Governance Manager. The Trust's Vice Chair and Chief Executive also attended some meetings in an observer capacity. A Governor observer was also in attendance at the majority of meetings.

5. COMMITTEE EFFECTIVENESS

5.1 In accordance with the Committee's terms of reference an annual assessment of committee effectiveness was undertaken to ensure continual improvement. Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2021/22 were reported to the Committee and actioned accordingly.

6. RECOMMENDATION

6.1 The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to formal submission to the Trust Board.

Jacqui Lyttle
Chair, Quality Assurance Committee
April 2022

Torbay and South Devon
NHS Foundation Trust

FINANCE, PERFORMANCE AND DIGITAL COMMITTEE

ANNUAL REPORT

2021/22

1. INTRODUCTION

1.1 The Finance, Performance and Digital Committee (the 'Committee'), in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 This report covers the work the Committee has undertaken at the meetings held during 2021/22. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

1.3 The Committee has powers delegated to it by the Board to:

(i) oversee, co-ordinate review and assess the financial, performance and digital management arrangements; including monitoring the delivery of the NHS Long Term Plan and supporting Annual Plan decisions on investment and business cases;
(ii) provide the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on the financial viability and sustainability of the Trust;
(iii) provide detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board;
(iv) assess and identify risks within the finance, performance and digital portfolio and escalating this as appropriate;
(v) make recommendations, as appropriate, on financial, performance and digital matters to the Board;
(vi) determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions as set out in the Trust's Standing Orders;
(vii) oversee the development of and approval of the Trust's medium term financial strategy; and
(viii) maintain a watching brief over the strategic direction of the Devon ICS as informed by relevant national policy, and informing the Board of such.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to:

(i) advise the Board on all aspects of key performance, financial and investment issues to enable sound decision-making;
(ii) provide assurance in respect of financial, performance and digital related matters along with business planning; and
(iii) provide assurance that corrective action has been initiated and managed where gaps are identified in relation to financial, performance and digital risks.

1.5 The Committee Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes the Director of Financial Operations, Interim Director of Environment, Health Informatics Service Director, and others who may be required to attend as necessary.

2.1.2 Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation, seeking specialist areas of expertise, attending Board of Directors and Council of Governors meetings, visiting services and talking to staff.

2.1.3 The Committee is assured that it has the right membership and attendance to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

2.1.4 Compliance with a number of the key responsibilities is evidenced by the following areas of work the Committee has received assurance on during 2021/22:

Financial performance

- received and reviewed in detail the Financial Plan for 2021/22 looking at the key financial risks associated with the plan
- received progress reports in regard to the development of the annual plan, including CIP development
- reviewed in detail the financial performance reports at each meeting, noting the underlying deficit and consequential impact on the longer-term financial outlook
- received and reviewed Covid-related expenditure (revenue and capital)
- received the year-end financial out-turn prior to being reported to Board
- received progress reports against the Trust's Cost Improvement Plan
- received confirmation of the outcome of the reference costs submission
- received assurance on the Trust Treasury management arrangements
- received assurance on the Trust's agency spend and pay reports
- reviewed the Trust's capital programme
- received a report on ICS long term planning
- reviewed financial performance of the Trust's subsidiaries and business divisions
- reviewed Covid financial management
- Review of the IPR and the need for a refresh

Performance

- reviewed the performance section of the integrated performance report at each meeting and reviewed assurance on the actions taken to improve performance related issues
- sought assurance on demand and capacity issues and compliance with national standards
- received deep dives into Cancer and CIP and Transformation performance
- received reports on the results of the Deloitte phase one work (Financial improvement programme)
- received a report on the operational structure reshaping
- received assurance on the Trust's progress against the Covid-19 Recovery Plan
- received assurance around nursing safer staffing and establishment review
- reviewed and approved a number of business cases including: acute medicine and frailty; Horizon Centre enhancements; phase 2 chillers; Torbay ambulance pod and the Emergency Department; N365 re-investment; and CT scanners.
- Received briefing on the Trust's recovery plan

Digital

- sought assurance on the Trust's approach to potential digital risks
- received assurance reports from the Information Management and Technology Group
- received digital related business cases for approval eg Digital SOC & OBC
- received feedback from the Internal Audit review into Electronic Prescribing Medicines Management review
- Received a report on the Information Commissioner's Officer Report and action plan

Estates

- received reports and business cases relating to the Trust's estate and property eg. Dartmouth, Teignmouth and Dawlish
- reviewed the Trust's Health and Wellbeing Centres Strategy from a financial perspective
- received reports on progress of the Trust's Commercial Strategy
- received outcome of the Estates Return Information Collection (ERIC) exercise

Governance

- received business cases for approval in accordance with the Trust's scheme of delegation and where appropriate recommended approval by the Board
- received progress reports on Trust matters eg S.106 Agreements
- developed a programme of post implementation reviews and received reports on such
- received reports from the Trust's subsidiaries and business divisions ie Torbay Pharmaceuticals
- received risk register reports relating to the scope of work of the Committee

- received the Board Assurance Framework in relation to those risks pertaining to the scope of the Committee
- received reports from Groups reporting to the Committee
- developed a Committee workplan for the year
- reviewed the meetings cycle and agreed a change to the reporting timetable
- undertook a Committee effectiveness self-assessment
- reviewed the Committee's Terms of Reference

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF') in relation to those risks within the scope of the Committee.

3.2 The Committee review of the BAF focussed on finance, performance and digital related risks. Deep-dives in to specific risks were commissioned on a risk-based approach.

4. MEMBERS AND MEETINGS

4.1 During 2021/22, the Committee met on a monthly basis (with one meeting taking place virtually). The meetings were quorate all times.

4.2 The record of Committee attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Paul Richards (Chair)	12 (12)
Chris Balch	12 (12)
Robin Sutton	10 (12)
Executive Directors	**Number of meetings attended**
*Ian Currie, Medical Director	10 (12)
John Harrison, Chief Operating Officer	7 (12)
Adel Jones, Director of Transformation and Partnerships	11 (12)
*Deborah Kelly, Chief Nurse	7 (12)
Dave Stacey, Chief Finance Officer	12 (12)

* Joint Membership

4.4 Senior management representatives also in regular attendance included – Deputy Director of Finance, Director of Corporate Governance and Trust Secretary and Corporate Governance Manager. The Vice-Chair/Audit Committee Chair and Chief Executive attended some meetings in an observer capacity. A Governor observer was also in attendance at the majority of meetings.

5. COMMITTEE EFFECTIVENESS

5.1 In accordance with the Committee's terms of reference an annual assessment of committee effectiveness was undertaken to ensure continual improvement. Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2021/22 were reported to the Committee actioned accordingly.

6. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to formal submission to the Trust Board.

Paul Richards
Chair, Finance, Performance and Digital Committee
April 2022

Torbay and South Devon
NHS Foundation Trust

PEOPLE COMMITTEE ANNUAL REPORT

2021/22

1. INTRODUCTION

1.1 The People Committee, in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 In establishing the Committee and agreeing the Terms of Reference, the Committee was mindful of the breadth and scope of work. Accordingly, the Committee work programme was devised to enable sufficient depth of discussion relevant to each topic. This process is well embedded and has been further enhanced with the approval of the Trust's People Plan.

1.3 The purpose of the Committee is laid down in its Terms of Reference, which is to provide assurance to the Board on the quality and impact of the People Plan and the effectiveness of people management in the Trust. This includes, but is not limited to, recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning, and organisational culture, diversity and inclusion. During the pandemic the Committee has also been seeking assurance on the arrangements for staff during what has been an incredibly challenging period for the Trust.

1.5 The purpose of this report is to provide assurance that the People Committee has carried out its obligations in accordance with its Terms of Reference.

1.6 This Report summarises the activities of the Trust's People Committee ('the Committee') for the year 2021/22 setting out how it has met its Terms of Reference and key priorities. In particular, it addresses various matters for which the People Committee has oversight for the Board, namely:

- national workforce guidance and strategies
- People Plan and associated activity/implementation plan(s) to support Trust forward strategy
- key people and workforce performance metrics and targets for the Trust
- assurance on those elements of the Board Assurance Framework in which the Committee has been identified as the overseeing Committee
- effectiveness of staff communication and levels of staff engagement
- strategic people and workforce issues at national and local level
- review of national staff survey results

1.7 The Committee also acted as an early point of contact for the Freedom To Speak Up Guardian to raise concerns prior to reporting to Board and the Trust's Freedom to Speak up Guardian has a standing invitation to attend Committee meetings.

1.8 The Chair escalates those matters that the People Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During the year the Committee has focussed on delivery of the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Review of the Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring.
- Conducted deep-dives in to the 'Valuing our Workforce' and 'Well-Led' sections of the Board Assurance Framework by focussing on for example, achievement reviews, just and learning culture, attraction and retention of talent, and the Trust's response to Covid-19 from a staffing perspective.
- Received reports on progress against development of the Trust's People Plan and recommended approval of the final People Plan named 'Our People Promise and Plan' to the Board. This included deep dives into each of the People Plan Pillars.
- Received assurance reports around education and workforce development in the form of reports covering medical education, medical appraisal and revalidation and the Education Annual Plan
- Received reports on the Workforce Transformation Programmes.
- Triangulated workforce information to reconcile headcount and finance data, staff sickness, vacancy rate and turnover by ISU and frontline staff groups.
- Reviewed equality, diversity and inclusion in depth by receiving reports and information from the Equality Business Forum Lead, WRES and WDES data.
- Received governance reports from those Groups with reporting responsibilities to the Committee.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting, most notably progress against the People Plan and the Trust's response to the Covid-19 from a workforce perspective.

3. RISK MANAGEMENT

3.1 The Trust continues to recover from the Covid-19 Pandemic and its continued impact on staff. The Committee has regularly discussed this at its meetings including impact on staff morale, support for leaders, and impact of staff choosing to leave the Trust as a result of the Pandemic.

3.2 During the year the Committee continued to maintain its review of the Corporate Risk Register ('CRR') and the Board Assurance Framework ('BAF'). The Committee's review of the BAF and CRR focussed on workforce related risks.

4. MEMBERS AND MEETINGS

4.1 During 2021/22, the Committee met formally on six occasions. The meetings were quorate all times.

4.2 Committee membership comprised three Non-Executive Directors and three Executive Directors. Vikki Matthews acted as Committee Chair. The Committee has been short of members since Jon Welch's retirement and Sarah Wollaston's resignation. Record of their attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Vikki Matthews (Chair)	5 (6)
Chris Balch	6 (6)
Jon Welch (retired 30.09.21)	2 (3)
Sarah Wollaston (in post from 01.10.21 to 29.11.21)	1 (1)
Executive Directors	**Number of meetings attended**
Judy Falcao, Chief People Officer	5 (6)
John Harrison, Chief Operating Officer	2 (6)
Ian Currie, Medical Director (joined Committee in December 2021)	2 (2)
Deborah Kelly, Chief Nurse	4 (6)

4.3 Senior management representatives are also in regular attendance included – Associate Directors of People, System Directors, System Medical Directors, Associate Directors of Nursing and Professional Practice, Freedom to Speak Up Guardian, Director of Corporate Governance and Trust Secretary and Corporate Governance Manager. The Trust's Vice Chair and Chief Executive also attended some meetings in an observer capacity. A Governor observer was also in attendance.

5. COMMITTEE EFFECTIVENESS

5.1 The Committee undertook a self-assessment review during the year, which concluded that the People Committee has delivered the majority of its responsibilities as set out in the Terms of Reference, attendance at meetings has been quorate and the cycle of business has been completed. The Self-Assessment process did highlight, however, the vacancy in NED membership due to the resignation of Sarah Wollaston shortly after she commenced in post, and the impact of holding a NED vacancy for an extended period on the Committee.

5.2 Areas for action identified as part of the self-assessment process were noted and addressed.

Vikki Matthews
Chair, People Committee
April 2022

NHS
Torbay and South Devon
NHS Foundation Trust

BUILDING A BRIGHTER FUTURE COMMITTEE

ANNUAL REPORT 2021/22

1. INTRODUCTION

1.1 The Building a Brighter Future Committee ('the Committee') was established as a Board sub-committee in October 2020 as the HIP2 Redevelopment Committee and changed its name in April 2021.

1.2 The Committee was set up in response to the announcement by the Government that Torbay Hospital had been confirmed as "one of 40 hospitals across the country to receive a share of £3.7 billion". The Board considered that the funding quantum and project complexity would require Board oversight and this would be best achieved through a Board Sub-Committee.

1.3 The Committee, in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.4 In establishing the Committee and agreeing the Terms of Reference, the Committee was mindful of the breadth, scope of work and timescale. The Committee work programme continued to be reviewed to ensure it enables sufficient depth of discussion relevant to the project.

1.5 The purpose of the Committee is laid down in its Terms of Reference, which is to provide assurance to the Board regarding the processes, procedures and management of the BBF Programme and to support the successful achievement of the Programme investment objectives and realisation of the stated benefits.

1.6 The Committee also provides assurance to the Board of the achievement of the objectives set out in the Programme; that approved projects are being effectively managed and controlled; and to confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable

1.7 The purpose of this report is to provide assurance that the Committee has carried out its obligations in accordance with its Terms of Reference.

1.8 This Report summarises the activities of the Committee for the year ended 31 March 2022 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Committee has oversight for the Board, namely:

- Establishing a programme of independent assurance to ensure the BBF Programme plan and its projects are managed and delivered in a controlled way.
- Receiving reports from the BBF Programme Group that address delivery progress, including, costs; key risks; outcome of assurance activities; and, actions to address recommendations including key decisions with reference to the capital development forward plan.
- Ensuring that prior to formal approval, confirmation that appropriate processes have been implemented and assurance activities completed on key BBF Programme documents, to include:

    - Programme and project delivery plans
    - Strategic Outline Case ('SOC')
    - Outline Business Case ('OBC')
    - Full Business Case ('FBC')
    - Contract and procurement strategies
    - Contract and works procurement documentation
- Ensuring that robust and effective governance arrangements are implemented to oversee the delivery of the BBF Programme and approved projects.
- Ensuring that appropriate internal and external due diligence has been completed prior to appointment of any preferred bidders/contractors in connection with any contract.
- Providing advice and support to the identification and effective control of the BBF Programme and any key project risks.
- Reviewing identified inter-dependencies across the Programme and its approved projects (and external to the BBF Programme) and ensure that controls are established to manage these effectively.
- Ensuring that effective control and risk management arrangements are implemented to manage the delivery of the BBF Programme and the approved projects within its control.
- Reviewing and providing assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance.
- Reviewing BBF Programme related risks identified on the Corporate Risk Register and seeking assurance in relation to risk mitigation and future activity/plans.
- Reviewing and advising the Board on the risks associated with any material issues as required from time to time. In preparing such advice, the Committee shall satisfy itself that a due diligence appraisal of the proposition is undertaken and is within the risk appetite and tolerance of the Trust, drawing on independent external advice where appropriate and available, before the Board takes a decision whether to proceed.
- Communicating information about the New Hospitals Programme and approved projects to key internal and external groups, staff, stakeholders, Governors and the general public.
- Actively championing internally and externally, the investment objectives and benefits of the BBF Programme.

1.9 The Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During the year the Committee has focussed on delivery of the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Developed a strategic objective for inclusion on the Board Assurance Framework, with appropriate challenge to the proposed gaps, controls and risk scoring.
- Developed risks to achieving the strategic objective which are regularly reviewed
- Received reports on progress against development of the SOC and then Digital OBC.
- Recommended approval of the Strategic Outline Case by the Board of Directors
- Recommended approval of the Digital OBC by the Board of Directors
- Received revised expenditure profile information for seed funding.
- Update reports from Technical Advisers and the appointment of Cost Advisers.
- Received HIP2/IM&T/Estates Interface Briefings.
- Received strategic sense check overview reports.
- Received regular progress reports and updates on timelines, finance, project status etc.
- Received Programme Office structure update reports.
- Received regular updates on the development of the site enabling business case.
- Received governance reports from those Groups with reporting responsibilities to the Committee.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting. Reports included a description of the business conducted, risks identified, assurance provided and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting, most notably progress against the project timeline/plan.

3. RISK MANAGEMENT

3.1 Since its establishment, the Committee has continued to maintain its review of the Corporate Risk Register ('CRR') and the Board Assurance Framework ('BAF'). The Committee's review of the BAF and CRR focussed on the hospital programme related risks.

4. MEMBERS AND MEETINGS

4.1 During 2021/22, the Committee met formally on 11 occasions and once as a virtual meeting. The meetings were quorate all times.

4.2 Committee membership comprised three Non-Executive Directors and three Executive Directors . Chris Balch acted as Committee Chair. Record of their attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Chris Balch (Chair)	12 (12)
Paul Richards	12 (12)
Jon Welch (retired 30/09/21)	4 (6)
Sarah Wollaston (in post from 01/10/21 to 29/11/21)	0 (2)
Executive Directors	**Number of meetings attended**
Ian Currie, Medical Director	8 (12)
Rob Dyer, Deputy Chief Executive & SRO (retired 04/07/21	2 (3)
Adel Jones, Director of Transformation and Partnerships & SRO (wef 05/07/21)	8 (9)
Dave Stacey, Chief Finance Officer	10 (12)

4.3 Senior management representatives also in regular attendance included – Programme Director, Deputy Programme Director, Programme Adviser, Interim Director of Environment, Company Secretary and Corporate Governance Manager. The Vice- Chair/Audit Committee Chair and Chief Executive attended some meetings in an observer capacity. A Governor observer was also in attendance.

5. COMMITTEE EFFECTIVENESS

5.1 The Committee has begun a formal self-assessment of its activities but the exercise is yet to be completed.

Chris Balch
Chair, Building a Brighter Future Committee
April 2022

Torbay and South Devon
NHS Foundation Trust

AUDIT COMMITTEE ANNUAL REPORT

1 APRIL 2021 TO 31 MARCH 2022

1. INTRODUCTION

1.1 The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 The purpose of the Committee is laid down in its Terms of Reference. In summary, it oversees the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place, reviews the work and findings of External Audit, reviews the Trust's statutory accounts before they are presented to the Trust Board and maintains oversight of the Trust's Counter Fraud arrangements.

1.3 The purpose of this report is to provide assurance that the Audit Committee has carried out its obligations in accordance with its Terms of Reference.

1.4 This Annual Report summarises the activities of the Trust's Audit Committee ('the Committee') for the financial year 2021/22 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Audit Committee has oversight for the Board:

- Financial reporting
- Risk management
- External audit
- Internal audit
- The system of internal control
- Governance arrangements, including the work of other Board committees.

1.5 The Chair escalates those matters that the Audit Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During 2021/22, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Regular review of the Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring.
- Review of the draft Annual Governance Statement.
- Received reports on progress against local counter fraud, internal and external audit plans and issues by exception.
- Agreed the external audit annual fee and work plan.
- Agreed the internal audit and local counter fraud annual work plans.
- Reviewed the draft annual accounts, draft annual report and draft quality report and recommended them for approval to the Trust Board.

- Reviewed specific Internal Audit reports and proposed actions for those areas identified with limited assurance (with the relevant Executive Director present when required) and monitored the follow-up of outstanding actions.
- Reviewed the effectiveness of Internal Audit, External Audit and the Local Counter Fraud Service.
- Reviewed the accounting policies, judgements and material estimates of the Trust and made appropriate recommendations to the Trust Board.
- Reviewed External Audit reports and the Annual Audit Letter, including progress on implementation of recommendations and any corrected or uncorrected misstatements in the accounts.
- Received the Clinical Audit Plan and Framework.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting. This included highlights of the results of the Internal Audit reports received at each meeting, providing more details in relation to those that were of limited assurance, which formed part of the evidence upon which the overall Head of Internal Audit opinion was based. They also included reports which considered the proper arrangements in place to secure economy, efficiency and effectiveness in the use of resources.

2.3 Work of the Committee

2.3.1 External Audit – Year-end processes continued to be disrupted by the Covid-19 pandemic, and in light of pressures caused by the public sector response to the pandemic a number of revisions were made to year-end reporting requirements.

The Trust's external auditor for the financial year 2021/22 was Grant Thornton. The Committee reviewed progress and final audit reports and management letters for 2020/21 and achieved submission of the annual report and accounts prior to the published submission deadline.

2.3.2 Internal Audit – The Committee works with the Internal Audit team (ASW Assurance). The Committee reviewed and approved the Internal Audit Plan and detailed programme of work. The Internal Audit Plan embraced operational as well as financial and business areas, and the Committee received a range of reports during the year for consideration.

The internal audit work for 2021/22 was on plan for completion by the year end, subject to any adjustments agreed by senior management and the Audit Committee through the year. The workplan was revised during the year to account for ongoing Covid-19 pandemic. All workplan amendments were discussed and agreed with the relevant Executive Director and reviewed by the Risk Group prior to presentation at the Audit Committee.

Shown below are the audit reviews presented to the Audit Committee during the year and the assurance rating.

AC meeting date:	Report ref.	Audit Review	Assurance rating
April 2021	TSD04/21	CQC	Significant
April 2021	TSD14/21	Debtors	Significant
April 2021	TSD13/21	Bank and Cash Management	Satisfactory
April 2021	TSD11/21	Combined Finance Review	Significant
April 2021	TSD39/21	Cyber Security - governance	Satisfactory
April 2021	TSD15/21	Payroll	Satisfactory
April 2021	TSD09/21	Transformation and CIP Plans and associated governance arrangements	Satisfactory
May 2021	TSD43/21	PWC Duplicate Payments	Not Applicable – management support
May 2021	TSD02/21	Risk Management	Satisfactory
May 2021	TSD18/21	Review of Capital Programme	Satisfactory
May 2021	TSD38/21	Safeguarding/Quality Assurance Improvement Team	Satisfactory
Sept 2021	TSD17/21	Estates and Facilities Management (Safety) Management	Satisfactory
Sept 2021	TSD24/21	Information Governance – DSPT	The overall risk rating as per the definitions set by National Data Guardian Standard (NHS Digital) for the assertions reviewed as **Moderate:** "*There are no standards rated as 'Unsatisfactory or 'Limited'. However, not all standards are rated as 'Substantial'*" based upon the evidence provided for review.
Jan 2022	TSD02/22	Board Assurance Framework	Significant
Jan 2022	TSD28/22	Transition of Young People from Children's Services	Satisfactory
Jan 2022	TSD14/22	General Ledger – Main Accounting and Ledger Journals	Satisfactory
Jan 2022	TSD13/22	Combined Finance Review	Satisfactory

As part of the annual reporting process, the Head of Internal Audit opinion will be confirmed at the stage of finalising the annual report and accounts for 2021/22.

The Committee received regular internal audit progress reports and continued to monitor the completion of outstanding report recommendations through updates and progress reports.

ASW Assurance continue to attend the Risk Group on a regular basis between Audit Committee meetings to report to senior management on progress and highlight any key risks to achievement of their internal audit plan.

2.3.3 Counter Fraud - The Trust takes the prevention and detection of fraud seriously. Each year the Committee receives and considers the Annual Counter Fraud Plan, regular progress reports and updates, and the Annual Counter Fraud Report.

The Local Counter Fraud Specialist (LCFS) is invited to attend the Committee twice yearly to give a presentation and update on the Plan, fraud prevention and cases reported and under investigation.

3. RISK MANAGEMENT

3.1 During the year, the Committee continued to review the risk management approach across the Trust. The Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF').

3.2 The BAF focuses on the key risks against achievement of the Trust's strategic objectives. The BAF is a 'live' document and is continuously reviewed and updated. This process is managed by the Director of Corporate Governance and Trust Secretary.

3.3 The Committee reviewed the BAF at each meeting to ensure there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, to ensure there are no major omissions.

3.4 The work of the Committee is not to manage the process of populating the BAF or to get involved in the operational development of the risk management processes, either at an overall level or individual risk level. These are operational issues that the Committee is satisfied are being carried out appropriately by management.

3.5 The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors' to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

3.6 A review was carried out by ASW Assurance during the year which concluded that the Trust's arrangements for the management of the corporate level risks continue to be implemented satisfactorily through the Trust Board and the delegation to its sub-committees and the Risk Group for oversight and monitoring of risk.

4. MEMBERS AND MEETINGS

4.1 During 2021/22, the Committee met formally on five occasions and once as a virtual meeting. An additional meeting to the usual frequency of meetings was held in June 2021 to review the final annual report and accounts for 2020/21, prior to submission to the Board of Directors for approval. The meetings were quorate all times.

4.2 The record of Committee attendance is shown below:

Non-Executive Director	Number of meetings attended
Sally Taylor (Chair)	5 (5)
Chris Balch	4 (5)
Jacqui Lyttle	5 (5)
Vikki Matthews	4 (5)
Paul Richards	5 (5)

4.3 Senior management representatives also in regular attendance included – Chief Finance Officer, Chief Nurse, Company Secretary and Corporate Governance Manager. Other senior managers also attended at the Committee's invitation.

4.4 The Trust's internal auditor and external auditor were in attendance at every meeting.

5. COMMITTEE EFFECTIVENESS

5.1 The Committee undertook a self-assessment review during the year, which concluded that the Audit Committee has delivered the majority of its responsibilities as set out in the Terms of Reference, attendance at meetings has been quorate and the cycle of business has been completed.

5.2 Areas for action identified as part of that self-assessment of the Committee's effectiveness to identify any gaps in the Committee's workings were noted and in the main, addressed.

5.3 The Committee will undertake an annual assessment to ensure continual improvement. Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2021/22 will be reported to the Audit Committee in Q1 2022/23.

6. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to its formal submission to the Trust Board.

Sally Taylor
Chair, Audit Committee
April 2022

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report April 2022			**Meeting date:** 25 May 2022
Report sponsor	Chief Operating Officer		
Report author	System Directors		
Report provenance	The report reflects updates from management leads across the Trusts integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)		
Purpose of the report and key issues for consideration/decision	The report provides an operational update to complement the Integrated Performance Report (IPR), including some specific performance metrics. The report offers greater visibility of activity not fully covered in the IPR. The Trusts recovery phase work is explored in more detail in this month's report alongside the reduction noted in Covid presentations and the subsequent positive impact on improving patients experience of moving through the urgent care system. The report explains the key activities, risks and operational responses to support delivery of services through this phase of the recovery and restoration planning including delivery of high priority cancer, diagnostics and elective services.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Chief Operating Officer's Report.		
Summary of key elements			
Strategic objectives supported by this report			

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register			

Board Assurance Framework	X	**Risk score**	20
Risk Register		**Risk score**	

BAF Objective – 2 To deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care and best experience

External standards affected by this report and associated risks				
	Care Quality Commission	**X**	**Terms of Authorisation**	
	NHS Improvement	**X**	**Legislation**	
	NHS England	**X**	**National policy/guidance**	

Report title: Chief Operating Officer's Report		**Meeting date:** 25 May 2022
Report sponsor	Chief Operating Officer (COO)	
Report author	System Directors	

1. Purpose

This report provides the Board with an update on progress and the controls in place in relation to operational delivery across the Trusts Integrated Service and Children and Family Health Devon (CFHD).

2. Introduction

This month has seen the continued progress of the recovery and restoration plan considered and approved at Board last month. This is alongside a reduction in patients admitted with Covid and reduced transmission of Covid. Business as usual has been restored in many areas with commensurate improvements in capacity. However, some clinical areas do not have the required capacity restored and remain challenged. These areas are the focus of our clinical and operational leadership teams. The impact of 2 years of restricted elective activity on waiting times is well reported nationally and will require a focus for many months and in some areas, years. It is however pleasing to report that progress on recovery has started. There is now intense local, national and regional focus on accelerating improvements in waiting times and to reduce to zero those waiting over 2 years for treatment by the end of June 2022.

3. System Recovery and Capacity response plan

The full functioning of the level 2 Acute Medical Unit (AMU), in conjunction with the restoration of the Day Surgery Unit (DSU), has had a significant impact on team morale and delivery in delivering an improved patient experience. The reduction in Covid presentations and transmissions has been a key enabler to reduce the number of Covid inpatients to a level which can be supported in the Covid annexe (8 beds) on the ward on level 6. The Urology team have reported to have settled in well into the facility in Paignton Hospital. Clinical space to support Urology in managing acute attendances within the acute hospital site will be available in the coming days.

To enhance infection control measures on our Stroke ward, sliding doors are being trialled on the bays on George Earl ward. This will enable our team on George Earl to test our ability to manage patients when required with support from our Infection, Prevention and Control (IPC) team and in doing to reduce the risk of ward closures disrupting the stroke pathway as a result of IPC issues.

4. Children and Family Health Devon (CFHD)

4.1 Transformation

The formal CFHD staff consultation is underway, this was originally due to close on 20th May, however it has now been extended until the 27th May due to the limited availability of trade union representatives to support staff with their individual meetings. Throughout the consultation, we have placed a strong emphasis on staff engagement, with information giving workshops, Q&A live events, support meetings and meetings with different staff groups. Staff have been very engaged, providing a large volume of feedback and we plan to evaluate this during June and thereafter, produce the paper outlining the final model.

Mobilisation of the new integrated service model is dependent upon 3 significant issues. Firstly, the interoperability issues inherent in delivering an integrated service which is provided by two organisations need to be resolved before the new model can go live. Approaches have been made to the two Transformation teams (Torbay and South Devon Foundation Trust and Devon Partnership Trust) to lead this work.

Secondly, the timescale for development of System One has been put back. Whilst we explore alternative options to prevent delayed implementation of System One, we will weigh up the viability and risks in operating an integrated service with two clinical record systems. It is therefore possible that the new model cannot not be implemented until System One is also operationalised.

Finally, we will need to undertake intensive work on waiting lists in order to significantly reduce long waits, where they exist, so that the new model can achieve adequate patient flow.

4.2 Children and Young People (YCP) system

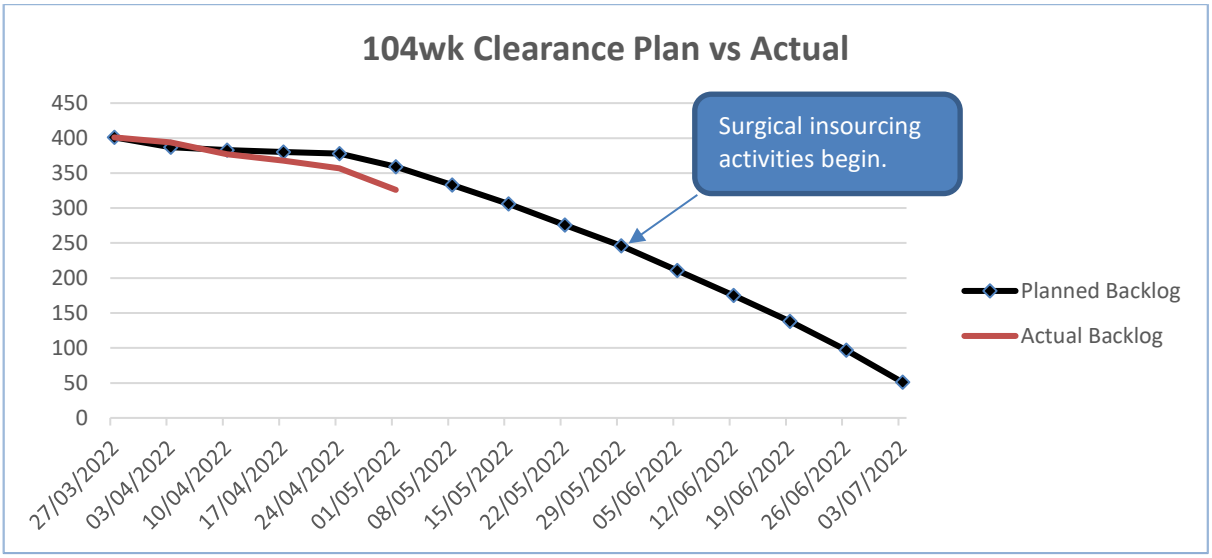
The Torbay SEND Written Statement of Action (WOSA) was approved by Ofsted and work has begun on the required actions. This will involve very significant time and staff resource. Identifying capacity to fulfil our obligations at the pace required will be a challenge.

A SEND inspection re-visit is taking place for the Devon County Council (DCC) area in the week of 23rd-25th May. This will be conducted by Ofsted and the CQC. CFHD leaders and clinicians will be involved in a number of focus groups and preparation for the inspectors' case tracking.

5.0 Coastal ISU: Elective / Planned Care – Surgical Activity

The plans to stand up the DSU and elective orthopaedic capacity following the relocation of the Medical Receiving Unit (now AMU) to level 2, progressed as planned and operating recommenced in both facilities on 23rd April. This has been greeted with great enthusiasm and joy across the Trust but particularly amongst staff in Coastal ISU. Most importantly the positive impact this will have on patients waiting for surgery will be very significant. In line with our stated principles, the most clinically urgent cases alongside the longest waiting patients are being prioritised by our booking teams.

In line with national guidance, plans have been submitted to eradicate 104-week waiters from the referral to treatment (RTT) position (Excluding patients choosing to delay treatment) by the 30th June 2022. Currently we have a shortfall of capacity to treat 51 patients within the plans. Accordingly, we are seeking mutual aid support from other Trusts, this is being co-ordinated at regional level. Whilst the standing up of Trust surgical capacity is critical, it is recognised that the challenging position faced by the Trust cannot be fully ameliorated without external support. It is expected that c.40% of the longest waiting patients will be treated by a combination of insourcing and outsourcing of surgical capacity from the private sector, outsourcing to the Nightingale Hospital in Exeter and securing mutual aid. We have, however made a good start and are currently ahead of our planned improvement trajectory.



The Gastroenterology team recently submitted plans to replace the endoscopy insourcing arrangements with a mobile unit which will be staffed by Trust clinicians and will come within the budget allocated for the service. Enabling plans are being developed and it is expected to have the mobile unit commissioned and fully functional at the beginning of September. The Trust has one of the most challenged backlog positions in the South West for endoscopic diagnosis and surveillance and this temporary development will help balance the capacity and demand in the short and medium term whilst long terms plans for endoscopy capacity are agreed and put in place.

Transformation opportunities - The Trust has recognised the transformation opportunities offered both from nationally mandated and local initiatives. These opportunities in outpatient and inpatient settings will be pursued with the support of the Transformation Team and the Programme Management Office (PMO). In addition, the Devon System will embark on a program of surgical innovation which will be fully supported by Torbay clinical and operational teams. The first priority for system developments is day surgery and ambulatory pathways using GIRFT (getting it right first time) and Model Hospital data to support decision making. The ambition across the county is to raise the bar to “best in class” for day-case and ambulatory care. Torbay is consistently ranked very highly against GIRFT targets and will make a significant contribution to this program of work.

6.0 Paignton and Brixham ISU: – Cancer and Diagnostics Update

6.1 Cancer Performance

March and April have seen a sustained improvement in two-week wait (2WW) performance, with both months reporting over 60%, which we have not achieved since July 2021. The key change has been dermatology currently achieving 70%, up from 18% in February. The overall Trust position is still heavily impacted by the Breast pathway, which is only seeing 25% of patients within 14 days.

The 28-day Faster Diagnosis Standard is also showing improvement and for both March and April and we achieved the required 75% performance target. Lower GI and Urology both have challenged diagnostic pathways, leading to their performance being 38% and 22% respectively.

Urology has completed a move to Paignton hospital in the last month which will provide a space for development and expansion of their services once they are established. The service is also being supported by Exeter for prostate biopsies, but the reopening of the day-surgery unit will allow this activity to become locally provided again in the near future. This is reliant on sustainable medical staffing and the team is currently being supported by locums until substantive consultants can be appointed.

Colonoscopy is the key diagnostic delay for Lower Gastrointestinal tumours, with waiting times currently at 23 days the impact on the 14 and 28-day standards is apparent. As described above, plans are now finalised for a modular unit to provide additional capacity.

The ENT Head and Neck service is experiencing significant medical staffing challenges with their two consultants off at the moment and returns not expected within the next 6 weeks. We have built a temporary solution with support from out Maxillofacial team and ENT surgeons from Exeter. This does not provide a full service and there is still a risk to delays with patient pathways, particularly follow-up appointments. A Devon System Mutual Aid request is being drafted to outline our current situation and formalise these arrangements.

A risk previously noted in Breast care was the provision of histopathology services from Exeter Labs. Two alternate providers have now been identified and contractual discussions are underway and aim to be completed within the next few days.

Staffing challenges remain within radiology and radiography – this being the key cause of our extended waits for first appointments, however the 28-day standard is still being achieved.

Dermatology have secured Elective Recovery Fund (ERF) funding to support the recruitment of a locum consultant for an additional 6 months – at this point we remain unsuccessful in finding a suitable candidate. Positively, we have recruited an Advanced Surgical Nurse who will conduct minor ops and diagnostics, paving the way for a new workforce model.

Waiting times from diagnosis to treatment remain under 31-days. The 62-day standard for April was 57%, in line with previous months. The above narrative explains the core challenges and changes needed to improve this position.

6.2 Diagnostics

CT waiting times have decreased marginally during the last month, in part through greater use of the Nightingale Hospital Exeter (NHE) facilities. During the latter part of April and early part of May improvement has been made in reducing the overall numbers of patients waiting for a CT scan. Within this good progress has been made in reducing the number of long waiters, i.e. those patients waiting over 6 weeks.

Demand for CT remains relatively static over the last 3 months although demand levels would be less during a month with bank holidays.

The issue of medical cover for contrast scans at the NHE has been partially resolved by the presence of a Royal Devon University Hospital (RDUH) Radiologist during some of the sessions we have been assigned. However, this is for 40% of sessions, which results in the capacity not being fully utilised as a result because there are insufficient patients requiring non-contrast studies to be sent to the NHE facility. An IT solution to help facilitate cover by our local Radiologists is being worked on, there is a lead time of 3-4 months.

CT staffing remains an issue but the risk is being mitigated through the use of agency staff. The team continue to actively recruit. The service has appointed an external applicant recently.

With regard to MRI, the NHE capacity has replaced the Torbay Hospital capacity lost through the cessation of double time payments to radiographers who were working additional hours. The service is expecting a successful recruitment process in the coming weeks.

Increased mobile capacity onsite at Newton Abbot is planned during May which will see a further reduction in the numbers waiting. Additional MR capacity is also being sought from Mount Stuart Hospital.

Both modalities lend themselves to additional mobile capacity. Although a potential second site exists at Newton Abbot Hospital a site survey has since indicated a significant amount of enabling work to be able to accommodate a second mobile scanner. Our Estates colleagues have indicated that no other site across the Trust Estate is suitable for a mobile scanning pad.

7.0 Newton Abbot ISU: - Urgent & Emergency Care

Attendances to urgent and emergency services are steadily increasing to pre-pandemic levels as the effects of reduced Covid restrictions bring normality back to public life. At the same time access to GP’s is improving with the out of hours service at evenings and weekends recommencing.

Both Ambulance handovers times and delays in the ED remain at high levels although there are signs of improvement.

The Medical Receiving Unit relocated to level two in April freeing up the DSU to commence treatments. The new location will be in place until Autumn 2022 when the new build completes and is able to provide increased space for the assessment of medical conditions reducing the need to attend the Emergency Department.

The Urgent Treatment Centre (UTC) at Newton Abbot continues to support the ED enabling patients to be seen promptly. The UTC is also able to offer a booked appointment for patients' urgent care needs via the 111 service.

8.0 Torquay ISU:

8.1 Child Health /Paediatrics

The CCG have recently awarded an exciting new project to Young Devon to provide in-reach support for children and young people on Louisa Cary Ward. They will provide 2 part-time Youth Workers for Torbay inpatients. This initiative will support those who are coming from traumatic backgrounds, homelessness, looked-after settings and experiencing a breakdown of their placements. They will be specifically looking at building relationships with children and young people on the ward, facilitating early discharge to more suitable placements locally, where therapeutic relationships would be enhanced and reduce the likelihood of repeat admissions to unsuitable places such as the acute children's ward.

The Child Health teams have participated in the new television advertising campaign: It's in your hands, this features local staff and we are looking forward to seeing these once finalised, in late May.

Two locum consultant paediatricians have been recruited, one starting in May and one in August to help cover vacant posts. Recruiting to the permanent posts is ongoing. There are also 2 new Safeguarding nurses and a Paediatric Liaison nurse joining the team

The team has received positive informal feedback for the support provided to partner agencies in the recent Torbay Ofsted inspection of Children's Service. The formal notification of the outcome is awaited. The Safeguarding Team have a service development day planned to consider alterations in working practice coming out of Covid.

8.2 Dietetics

The Level 2 Weight Management Service benefitted from additional Pubic Health England (PHE) funding over the past 6 months. This has enabled the provision of additional weight management groups until the end of June. The team are now seeing an increase in referrals for both adult and child weight management, but unfortunately the additional PHE funding is not planned to be extended. Conversations are underway with the CCG in shaping strategy for weight management services for the future, as an essential part of supporting prevention work (NHS Long Term Plan).

Two First Contract Practitioner Dietitians have been subcontracted to Primary Care Network roles who are now completing their first year in post. The roles are focussed primarily around frailty and malnutrition and practices are benefiting from expert timely advice available to patients. They are also able to work collaboratively with the Community Team to avoid duplication and to enhance seamless care.

On 1st May the Eternal Feed supplier changed from Fresenius-Kabi to Abbott UK. This is part of a peninsula wide contract. Abbot UK supply tube feeds, oral nutritional supplements and plastics for the hospital and home delivery of feeds and plastics to more than 200 patients at home who are reliant on tube feeds for their nutrition. The team are grateful for support and collaborative working from Abbott UK colleagues as well as dietitians, pharmacy, procurement, catering, medical electronics and ward staff.

8.3 Children's Torbay 0-19 Service

A wide range of resources have been created for families and young people around topics including:

- Anaphylaxis
- Child Development
- Oral Health
- Sleep
- SEND
- Sexual health and young people
- Young people and drug & alcohol support
- Toileting

All resources will be available on-line as well as packs of information for schools. Awareness sessions are being organised and are designed to help start a conversation about the topic.

This is part of a wider development on the school age child offer, with plans for a named school nurse for each Torbay school. Plans have been developed to have school drop in sessions and further integration with wider teams and services e.g. Mental Health in Schools (MHST) team; whilst there is a very small school nurse capacity the plan is to maximise the reach and develop resources and pathways to support our 5-19-year olds across Torbay.

8.4 Healthy Lifestyles

Torbay Council are inviting providers to attend a second market warming event in preparation for the tender launch expected in June and bid submission in July. The exact details of the commissioning intentions have not yet been formalised but likely to include the following:

- Specialist Stop Smoking
- Weight Management (tier 2)
- Physical activity advice & interventions
- Behaviour Change Training e.g. MECC (Making every contact count), Connect 5
- Wraparound brief advice e.g. mental health, oral health & substance misuse

There will be a focus on health inequalities and priority groups.

8.5 Maternity

The 2021 national CQC Maternity survey results have been published and shared with Trust board at the end of March. We received some fantastic feedback from local families about their experience of care during their maternity journey. Choices for location of birth, mental health awareness and follow up care and advice were highlighted as great examples of care. An action plan has been devised to address the areas for improvement.

Jo Bassett commenced in post as the new Head of Midwifery and Gynaecology / ADNPP in March 2022. Jo is looking forwarding to driving change forward to sustain and improve services for Women's Health.

Recruitment strategies are having a positive effect on the vacancy position within maternity services.

The Ockenden final report was published in March 2022. The team are benchmarking themselves against the 15 essential actions and a Board Seminar is planned to address wider learning for the organisation.

System 1, the new EPR for maternity, goes live on 3rd May 2022. The team have worked incredibly hard to ensure operational readiness.

9.0 Torbay System: - Community Services and Independent Sector

9.1 Torbay Drug & Alcohol Service

In collaboration with partners our team has been successful in securing the 'Drug and Alcohol Treatment Service' element of the Torbay Council tender for clients with multiple complex needs. This is great news and provides an opportunity to improve services for our population by reinforcing the excellent partnership working demonstrated in securing the tender as we now move into the mobilisation phase of the work.

Over the last nine months, as part of developing this unique integrated service delivery offer for this tender opportunity, the team have been working closely in partnership across the four local organisations:

- Devon Partnership Trust (DPT)
- EDP Drug and Alcohol Service (EDP)
- Jatis
- Torbay and South Devon NHS Foundation Trust (TSDFT)

Through hard work and effective collaboration, an inclusive and agile partnership has been developed together, focusing on the breadth of knowledge, skills, strengths and expertise of each organisation, to create a bespoke integrated service model to effectively deliver the 'Drug and Alcohol Treatment Service' in Torbay aligned to the Commissioner's Alliance Vision and Principles. Through key stakeholder engagement, including local service users, it was agreed the new proposed integrated service would be named, 'Torbay Recovery Initiatives' (TRI). Contractually, TSDFT will operate as the Prime Provider, with principal sub-contract arrangements with DPT, EDP and Jatis.

9.2 Reablement centre development

Initial plans are in development for the commissioning of a 24-bed rehabilitation unit in Paignton focussed on supporting people to transition home with minimal ongoing services and preventing admissions to bed based care (including the acute). This is part of planning for winter 22/23 considering systemic workforce issues, Covid and to support the increased demand levels in the community at a time where supply is restricted.

9.3 Supported Living Framework

The supported Living framework closed 22nd April and evaluation is underway to award new contracts with providers. This is a key service in delivering the strategic blueprint and supporting people to live as independent as possible in the community

9.4 Extra Care Housing

The new provider has mobilised in Torbay and there have been a number of complex issues which require careful managing and modelling and in conjunction with forward planning for the 2 new schemes which should start building in 2-3 years' time.

9.5 Market Management, Supply and Demand

Demand for bed-based care exceeds supply in the market as well as increased complex care and a requirement to discharge from the acute hospital swiftly to enable system flow. This has impacted the level of fees which have increased. Work is underway to review short – term contracts within domiciliary care, block beds and their impact on this. A new Care Home contract will be developed over the next 12 months to improve the position with the care home market in conjunction with the government mandated financial work.

9.6 Fair Cost of Care

The project brief has been completed and the timeline of activity and resource prepared. We are working jointly with Torbay Council who have additionally been working to procure financial resource for the project. Communications have gone to the providers and workshops will follow to support the input of data.

10.0 Moor to Sea (M2S)

Ongoing pressures across all services as reported in previous months. Healthcare of Older People Team (HOP) are now providing medical cover for Totnes Hospital. This cover is entirely dependent on retaining a locum in the service to release consultant time. The team have continued to provide cover for Joan Williams Ward and have been deployed thinly over a number of our other wards including providing outlier cover.

The Acute Frailty service has been maintained throughout and data analysis is now beginning to show the benefits of the service.

11.0 Conclusion

Significant progress has been made this month operationally across all areas and there is a sense of positivity returning. The teams have been able to provide more attention to transformation, cost improvement planning and delivery as a result of this optimistic phase.

12.0 Recommendation

The Board is asked to review and note the contents of this report.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Directorate of Transformation and Partnerships Quarterly Report			Meeting date: 25 May 2022
Report appendix			
Report sponsor	Director of Transformation and Partnerships		
Report author	Director of Transformation and Partnerships		
Report provenance			
Purpose of the report and key issues for consideration/decision	The Board is asked to receive and note the update from the Directorate of Transformation and Partnerships, particular areas of note are: • The significant progress of the Digital Outline Business Case and system leadership of the collaborative approach to digital transformation. • The Improvement and Innovation strategic plan is now ready for launch and will be presented to the FPDC on 23rd May 2022. This will describe our ambition to underpin the delivery of our corporate objectives through a focus on increasing the capacity and capability of improvement and innovation within the organisation, making it everyone's business to improve their work, while doing their work. • The Building a Brighter Future team have commenced the Drumbeat meetings, which will ensure that the next phase of the health and care strategy is co-produced with our clinical teams.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked receive and note the report.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** X | **Valuing our workforce** X **Improved wellbeing through partnership** X | **Well-led** X		

Is this on the Trust's Board Assurance Framework and/or Risk Register	<table><tr><td>**Board Assurance Framework**</td><td>X</td><td>**Risk score**</td><td>25</td></tr><tr><td>**Risk Register**</td><td>X</td><td>**Risk score**</td><td>25</td></tr></table> BAF Risk 1 – Implement the Long-Term Plan – Risk 20 BAF Risk 6 – Maintain a fit for purpose digital infrastructure – Risk 25 BAF Risk 7 – Implement Trust plans for transform services – Risk 16 BAF Risk 10 – Actively manage the potential for negative publicity – Risk 9 BAF Risk 11 – To develop and implement the Trust Building a Brighter Future programme – Risk 16
External standards affected by this report and associated risks	<table><tr><td>**Care Quality Commission**</td><td></td><td>**Terms of Authorisation**</td><td></td></tr><tr><td>**NHS Improvement**</td><td></td><td>**Legislation**</td><td></td></tr><tr><td>**NHS England**</td><td></td><td>**National policy/guidance**</td><td></td></tr></table>

Report title: Directorate of Transformation and Partnerships Quarterly Report	**Meeting date:** 25 May 2022
Report sponsor & author	Director of Transformation and Partnerships

1. Introduction

The Directorate of Transformation and Partnerships continues to provide support to deliver key corporate objectives. This paper provides a summary of the work and ambitions for the next quarter, from the perspectives of each of the valuable teams within the Directorate.

2. Strategy and Provider Partnerships – Lead Chris Winfield

The Trust Board approved the Trust Strategy in January 2022, as a result of a significant level of engagement. The intention is now to ensure that the strategy is focussed on delivery.

Capacity issues relating to our communications infrastructure and the capacity of our Strategy Lead, have delayed a thorough launch of the communications material that supports the launch of the Trust Strategy. This will be prioritised over the next quarter.

The delivery framework and enabling plans are under development and inform the Board Assurance Framework. The Strategy Lead is working with the Director of Corporate Governance to ensure that the Trust objectives, priorities, risks and mitigations are reflected in the new BAF.

3. Improvement and Innovation Team – Lead Dawn Butler

The team have concluded the Improvement and Innovation concluding the final stages of the Improvement and Innovation Strategic plan and this will be presented to the Finance Performance and Digital Committee. The “Torbay way” will be launched on 25th May with staff. This work will form a core part of the delivery plan for the Trust strategy and will ensure that there is a comprehensive approach and resource to deliver the four pillars of improvement and innovation, which include:

- **Quality improvement and capability building**
- **Cost improvement, Recovery and Sustainability**
- **Trust Improvement Programmes**
- **Strategic Transformation and Innovation**

Our Quality Improvement Coaching programme was launched this week with clinical leaders from across our organisation joining the programme and choosing a quality improvement project to lead in their area, whilst they develop their skills. This work is aligned to the Trust Quality Strategy that will be launched in the Summer by the Chief Nurse and will underpin our ambition to achieve our four quality goals.

Work continues with Deloitte and our System Leadership teams to ensure that we have a robust financial recovery plan, supported by our Transformation Team. There remains a significant risk around the capacity and capability within the organisation to

deliver the size and scale of change required. This will be addressed as part of a business case that will come to FPDC n June 2022 and will be clearly aligned to the delivery of our financial improvement programme.

4. Project Management Office and CIP Development – Lead Richard Tregidgo

The new PMO process has been launched and will underpin the delivery of the financial plan for 22/23. The PMO have worked with closely with the Financial Improvement Director and Deloitte to ensure that all scheme benefits are transacted and project plans delivered.

The new team is now in place and working alongside ISU colleagues to ensure that when financial improvement projects are identified they follow due diligence to ensure that benefits are delivered.

5. Health Informatics Service (HIS) – Lead Gary Hotine

The HIS team continue to drive the schemes supported within the capital plan to delivery. Using the Trust prioritisation matrix, the team have contributed to the IM&T capital development plan, ensuring that the critical needs of Torbay are fully understood and articulated through the ICS Digital Strategy.

Much of the focus of the team has been to ensure that we are “match fit” for our future, critically this work includes:

- The development of the Outline Business Case (OBC) for an Electronic Patient Record
- Providing system leadership to ensure that the collective option within the OBC is optimised and has support for system partners
- Ensuring that all avenues for support from regional and national colleagues are explored in relation to digital sources of funds
- The delivery of the four priorities within the Digital Strategy

The Digital OBC will be presented to the National Joint Investment Committee on 20th June 2022 and conversations regarding the source of capital and the implementation arrangements are progressing at pace.

It is important that Board should note and acknowledge the very significant level of focus and contribution that this team is making to improve our digital future, providing a foundation on which we can transform and to ensure that the digital risks that the Trust has built up over time are resolved. I would like to pass on my gratitude to this leadership team, who despite the national uncertainties are garnering support and seeking solutions.

6. Communications and Partnerships Team – Lead Jane Harris

Our communications and engagement team continue to improve their offer to support internal and external communications, much of which is articulated in the Chief Executive briefing. Strategically the implementation of the communications review is underway and we are following the process of staff engagement to ensure that we have the right capacity within this important team to deliver our Trust communication and engagement team.

7. Building a Brighter Future Programme

The team continue to provide successful leadership of this ambitious and important transformation programme. The credibility of the team is recognised nationally and is a critical aspect of building confidence with the national decision-making bodies as we proceed with approvals for New Hospital Programme (NHP) funding. The Trust Board receive regular updates on the programme through the BBF committee and therefore this won't be repeated in this update.

- The Drumbeat Programme was successfully launched in April 20222 and 14 specialties have commenced their work over the next 20 weeks to help us to co-design our Brighter Future. This work, is embedded in our current care model and therefore in addition to helping us to design our new services, we have also ensured that the ideas generated will inform our Trust transformation plan to ensure we deliver safe, efficient and effective services in the short and medium term.
- The Digital Outline Business Case (OBC) is being presented to the National Joint Investment Committee on 20th June 2022 following significant scrutiny from the Regional teams.

8. Recommendations

The Board is asked to note this contribution as outlined in the quarterly report from the Director of Transformation and Partnerships.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Estates Performance and Compliance Group Report			Meeting date: 25 May 2022
Report appendix			
Report sponsor	Deputy CEO & Chief Finance Officer		
Report author	Director of Environment		
Report provenance	Estates Performance and Compliance Group Estates & Facilities Management (EFM) Senior Management Team Meeting		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to brief the Trust Board on EFM performance and compliance exceptions for March and April 2022.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To note the current performance and compliance of Estates and Facilities directorate and headline summary of key exceptions and activities		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience		**Valuing our workforce**	
Improved wellbeing through partnership	**X**	**Well-led**	**X**

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	25
Risk Register	2179	**Risk score**	16

Objective 5: To provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	**X**
NHS Improvement	**X**	**Legislation**	**X**
NHS England	**X**	**National policy/guidance**	**X**

Legal, financial and reputational implications of the consequence of any regulator enforcement notices/action.

Report title: Estates Performance and Compliance Group Report		**Meeting date: 25 May 2022**
Report sponsor	Deputy CEO & Chief Finance Officer	
Report author	Interim Director of Environment	

1. Introduction

This report summarises Estates and Facilities performance and compliance for March and April 2022 and provides a headline summary of the key exceptions and activities within the division.

2. Headline Summary

2.1 Dawlish PFI Expiry

The Interim Director of Environment will undertake a review of statutory compliance and asset condition later this month. This will help to inform whether the Trust is able to negotiate a lower settlement below the purchase price cap of £1.6m. The PFI provider is actively working to support this exercise.

2.2 Corporate Health & Safety

A Notice of Contravention (NOC) was issued to the Trust by the Health and Safety Executive (HSE) in April 2022. This related to a large number of staff COVID absences between 2020 and 2022, which should have been reported under RIDDOR regulations but were not. Under the supervision of the Deputy Director of Environment, and with additional administrative support, the Corporate Health & Safety team are conducting a line by line review of all COVID absences for 2020 to 2022 using DATIX and workforce data and reporting any incidents which should be categorised within RIDDOR.

At the point of the NOC being issued, there were 2,788 staff COVID absences which required review, there are now 1,850 to review with a deadline of 1st August 2022 as agreed with the HSE. Of the incidents reviewed so far, 2% were identified as being RIDDOR reportable. Daily updates are being sent to the Trust's contact at the HSE; these are also supplemented by a fortnightly meeting between the HSE and the Deputy Director of Environment. The HSE has confirmed its satisfaction with the Trust's approach and progress in this area.

Root cause analysis to identify the reasons for the failure which resulted in the NOC has been undertaken and remedial activities are underway. Generally speaking this takes the form of training for clinical staff on the appropriate use of DATIX and identifying RIDDOR reportable incidents. This activity is being sponsored and supported by the Chief Nurse.

In April 2022 the Trust's Authorising Engineer (AE) for Fire Safety, Darren Kirk, undertook a pre-planned annual audit of the Trust's fire safety management system. Due to COVID restrictions, this was the first audit of its kind since 2019. Generally speaking the AE was pleased with the improvements in management focus and did not feel as though the Trust was operating dangerously in respect of fire safety. The AE did express some areas where the Trust was operating to an unsatisfactory standard, though recognised that this was already understood by the Trust and that remedial plans were already in place to address these.

A series of recommendations have been made by the AE to improve the Trust's approach to fire safety management and compliance with the relevant statutory and regulatory guidance. These recommendations have been formulated into an action plan which will be managed through the Trust's Fire Safety Group which is accountable to the Health and Safety Committee.

2.3 Dartmouth Hospital Disposal

Dartmouth Town Council (DTC) have now concluded their procurement process to select a preferred development partner to support their community bid, with a clear mandate to deliver optimal social value to the communities of Dartmouth, this was approved at an extraordinary council meeting on the 16th May. The delivery of social value will be administered through Dartmouth United Charities. The Trust and DTC have also completed negotiations on the sale price for the former hospital site. A paper will be presented to Trust Board in private on 25th May.

2.4 Acute Medical Unit (AMU)

Programme delivery in this area continues to progress well. It is currently susceptible to a series of challenges associated with contractor attendances and supply chain for key construction components, due to the ongoing impact of Brexit and Covid19. The project board are working with the principal contractor in order to maintain the existing target completion period of autumn 2022 and to minimise the impact of these risks on the overall delivery of the programme. The principal contractor has reported prospective programme slippage to October 2022, which will be carefully monitored and reported as appropriate. The Estates team are now working towards a soft landings commissioning programme with operational and clinical colleagues to ensure the completed project can transition into clinical operation seamlessly.

2.5 Dartmouth Health & Wellbeing Centre

With construction of the new Centre physically reaching its highest point, a Topping Out ceremony was held on 26th April attended by a small group of invited guests, including the Trust's Chairman, Chief Executive and clinical representatives. The group enjoyed seeing the work underway and the overall footprint of the Centre.

The construction programme continues to progress well with the roof of the building finished, enabling internal works to commence with the installation of partitions helping to define the internal layout of the building. Outside, the car park base and curb edging are in place.

The main contractor continues to make good progress, within a challenging construction climate. However, a formal notification of a 6-week delay to programme is being reviewed by the Project Manager to determine whether an alternative approach can be identified to maintain the original programme.

2.6 Teignmouth Health & Wellbeing Centre

With the planning application for the original development still in planning hiatus, the Trust has progressed discussion with Teignbridge Council to identify whether there was the potential to purchase a larger neighbouring site on which a hotel development was proposed, but had fallen through.

The Council considered selling the site for healthcare development at its Committee meeting on 28th April, and it approved the sale of the land, subject to contract. The Trust and Council are now working to agree the Heads of Terms for the land purchase. Once Terms are agreed, the design team will prepare a second planning application for development of the Health & Wellbeing Centre on the new site, which will be submitted in August 2022. The site will enable a lower density development with a greater parking provision, both of which were identified as the main obstacles of the original plan.

2.7 Critical Infrastructure Update

The estates capital projects team continue the delivery of a number of key critical engineering and building infrastructure projects that will ultimately reduce risk and improve our environments while enhancing the business continuity and resilience of our core services. These works have to be meticulously planned to minimise impact, though inevitably will involve a level of short-term inconvenience in terms of areas being either closed, cordoned off, and/or subject to carefully planned service interruptions (shutdowns). The estates project team will work closely with Trust operations colleagues, emergency planning officers and our communications team to ensure inconvenience to patients, visitors and staff is minimised and patient and staff safety is maintained at all times. Projects include:

- Upgrading high voltage power systems
- Upgrading emergency generators
- Fire precaution works
- Upgrades to critical ventilation systems

2.8 Delivering the Trust's Recovery Plan

The Estates Development team has been working with clinical colleagues to deliver the Trust's Recovery Plan. This has meant working at pace to relocate services and achieve safe environments for patients and staff, with minimal disruption. The programme has successfully delivered the opening of a Medical Receiving Unit on Level 2 of the podium building, reopening the Day Surgery Unit and the re-location of Urology services to Paignton.

3. Compliance Overview

The EFM Operations team routinely assess 129 metrics of productivity and compliance, of which 44 key compliance indicators are measured against an expected performance standard. A summary of the in-month achievement of compliance indicators is included in Table 1 below.

Table 1 has been assessed against the following standards criterion.

Tier 1 - Implementation	Evidence of Planned Preventative Maintenance Delivery, Defect Logs and External Contractor management
Tier 2 - Assets and Infrastructure	Evidence of specific asset groups and condition management
Tier 3 - Management Systems	Evidence of Policies and Management Plans, Roles and Responsibilities, Training, Risk Assessments and Committees / Management Groups.
Key	• Blue = Excellent • Green = Good • Yellow = Minimal Improvement Required • Amber = Significant Improvement Required • Red = Inadequate

Table 1: Compliance Summary

Compliance Item	Tier 1	Tier 2	Tier 3	This month Total	March 2022 Total	February 2022 Total
Water	82.50	82.50	90.00	**85.00**	85.83	85.67
Fire	77.50	67.50	80.00	**75.00**	75.00	70.67
Medical Gases	88.33	86.00	78.00	**84.11**	85.44	85.83
Electrical Power / Resilience	88.00	77.00	88.00	**84.33**	84.33	86.50
Critical Ventilation	80.00	72.50	82.50	**78.33**	79.00	71.22
Lifts / LOLER	87.50	85.00	88.00	**86.83**	86.83	82.00
Pressure Systems	96.67	87.50	87.00	**90.39**	90.39	83.22
Asbestos	82.50	85.00	73.00	**80.17**	80.83	80.83
Cleaning	97.50	98.00	92.00	**95.83**	95.83	92.83
Waste	90.00	83.33	88.00	**87.11**	87.11	90.00
Catering	90.00	78.00	95.00	**87.67**	87.67	86.33

3.1 Exception Reports

Fire Safety: Planned maintenance regimes are largely up to date and complete. However, due to the significant high levels of remedial actions required relating to the current levels of backlog maintenance, moving to a fully compliant position is challenging given the condition of the estate.

A comprehensive fire risk assessment programme has been developed and will be conducted under the leadership of the Trust's Corporate Health & Safety Manager. This programme prioritises high risk inpatient areas, with progress being reported and discussed at the Trust Fire Safety Group.

The 2022 Fire Safety Audit conducted by our Authorising Engineer for Fire Safety (AEFS) has identified a gap in the Trust's Dangerous Substances and Explosive Atmospheres Regulations assessments (DSEAR). These will be undertaken across June and July using a specialist third party consultant.

The AEFS has also identified that our fire evacuation strategy across a number of areas of the estate requires improvement. This is being addressed by the Corporate Health & Safety team, working in partnership with the AEFS and the Trust's Emergency Planning Lead.

Ventilation Management: Critical ventilation systems serving Ophthalmology, Day Surgery Unit 3, Ricky Grant Unit and Nuclear Medicine are currently at end of life. An enhanced maintenance regime has been implemented as mitigation while longer term solutions are assessed as part of the overall backlog remediation programme.

Extensive refurbishment of critical ventilation systems has been undertaken in recent months to extend the serviceable life and sustain the performance of ventilation systems supporting the Cath Lab, HSDU and Linac 4.

Building Fabric and Environment: Work continues to proactively engage with clinical teams and deliver aesthetic uplifts to the fabric of ward areas in order to improve patient and staff experience. This included publishing a series 'non-negotiables' which are clear minimum standards for clinical settings that colleagues and patients should expect to see and experience.

The EFM leadership team are currently developing a method of measuring the quality of the building fabric and the built environment. Once developed, this will be included as an additional metric on the compliance summary (table 1) in future reports.

3.2 Performance Improvements

The in-month performance dashboard was reviewed by the Estates Performance and Compliance Group (EPCG) on 18th May and an action log has been updated and will continue to be used by the EFM Operations Leads to take forward measures of improvement, with a review of progress reported to future EPCG meetings. Performance standards of the two PFI Contractors operating at Dawlish and Newton Abbot Hospitals and of the Community sites maintenance

contractor have been similarly reviewed, with the in-month metrics incorporated into Table 1.

4. EFM Workforce Headlines

- **Sickness absence**: Decreased in month and for the rolling 12-month period. Mental Health remains the most significant reason for absence. 67% of the division's sickness is long term.
- **Achievement Reviews:** Significant improvements in respect of achievement reviews have been made since the last report with a green RAG rating of 92%.
- **Mandatory Training**: Overall compliance is RAG rated green at 88%, although Information Governance and Safeguarding training remains low across the Directorate and needs to be addressed. There are six teams that are not achieving the overall average rate for all mandatory training.
- **Staff Turnover**: Within the acceptable range for the EFM division.
- **Fatigue Indicator:** There are currently no teams that have triggered three of the four fatigue indicators
- **Organisation Design:** An organisational re-design of the EFM operational teams is planned to commence in quarter one of the 22/23 financial year. The proposed change was shared with the Trust's Partnership Forum on 31st March 2022 with no concerns raised by stakeholders.

5. Conclusion

The Trust Board is asked to note the current performance and key headlines of the Estates and Facilities Directorate.

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST PUBLIC BOARD OF DIRECTORS MEETING HELD IN THE BOARD ROOM, TORBAY HOSPITAL AND VIA MICROSOFT TEAMS AT 11.30 AM ON WEDNESDAY 27 APRIL 2022

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	* Mrs V Matthews	Non-Executive Director
	* Mr R Sutton	Non-Executive Director
	Ms L Davenport	Chief Executive
	* Mr D Stacey	Deputy Chief Executive Officer and Chief Finance Officer
	* Mr I Currie	Medical Director
	* Mr J Harrison	Chief Operating Officer
	* Ms A Jones	Director of Transformation and Partnerships
	* Ms D Kelly	Chief Nurse
	* Mrs J Falcao	Chief People Officer
	* Dr J Watson	Health and Care Strategic Director
In attendance:	* Mr O Raheem	Interim Director of Corporate Governance and Trust Company Secretary
	Mrs S Byrne	Board Secretary
	* Mrs J Bassett	Head of Midwifery
	* Mr J Bradley	Ward

* via Microsoft Teams

76/04/22 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

77/04/22 **Apologies for Absence and Quoracy**

There were no apologies of absence for the Board to note.

78/04/22 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

79/04/22 **Declaration of Interests**

There were no declarations of interest.

80/04/22 **User Experience Story**

Ms Kelly introduced Mr Bradley, Ward Manager, Simpson Ward and Chair of the Band 7 Council. He brought to the Board's attention the need to support Band 7 leaders; and champion leadership development skills from Band 4 upwards.

Mr Bradley provided the Board with an insight into his career as a Nurse during which he had gained corporate experience. With the support of his line manager he had, recently been accepted on the Senior Leadership Team Apprenticeship Course and explained he had consciously chosen the course due to the diversity of the experience it offered.

Mrs Matthews commended Mr Bradley's ability to recognise gaps in his skill set and how he had undertaken a series of learning to develop himself. She would like to see greater opportunities for Trust staff to broaden their experience and develop their careers.

In answer to a question by Mrs Matthews on the most impactful part of his learning, Mr Bradley explained the need to understand the right timing and the courage to take on opportunities and experience when they become available..

Mrs Falcao recognised the impact of Mr Bradley seeking opportunities outside of the Trust had had on his career and the benefits it brought to his leadership skills. She explained the Trust was seeking to embed talent management and work with other organisations to enrich learning for staff.

Ms Kelly explained the Band 7 Council had given the Trust's nursing leadership the opportunity to shape the nursing professional leadership programme, building in succession planning. She explained the need for the Trust to focus on incentivising the benefits of patient facing leadership roles.

Mr Harrison reflected on the effective leadership skills of Mr Bradley and the benefits this had provided to his department. Dr Watson also commented positively on the positive impact of Mr Bradley's leadership skills whilst working with the medics.

Mrs Davenport reflected on the need for supporting those in nursing leadership roles and on the benefits that system working would have on skilling future leaders.

Consent Agenda (Pre-notified questions)

Reports from Executive Directors

81/04/22 **Chief Operating Officer's Report - April 2022**

The Board received the Chief Operating Officer's Report of April 2022, as circulated, from Mr Harrison.

The Board received and noted the Chief Operating Officers Report.

For Approval

82/04/22 **Unconfirmed Minutes of the Meeting held on the 30 March 2022 and Outstanding Actions**

The Board approved the minutes of the meeting held on 30 March 2022 subject to the following two amendments:

- Page 7, 67/03/22, bullet point 4 be amended to, …'**daily** live reporting positions'…
- Page 7, 67/03/22, bullet point 5 be amended to, 'There would be a **continued** focus on strengthening of risk assessments and governance frameworks…'

Outstanding actions were noted as complete.

The Board approved the minutes of the meeting held on 30 March 2022.

For Noting

83/04/22 **Parking Lot of Deferred Items**

The Board received and noted the Parking Lot of Deferred Items.

84/04/22 **Report of the Chairman**

The Chairman verbally briefed the Board on the following key events:

- The Acute Provider Collaborative meetings had been established and he attended the April meeting with Mrs Davenport and Mr Currie. Royal Devon University Hospital, University Hospital Plymouth and Royal Cornwall Hospital were also represented.
- Recruitment into the Chief People Officer post and Non-Executive Directors posts had been commenced. He reported there had been interest from high calibre candidates.
- He visited Totnes Community Hospital on 19 April 2022, who were preparing for changes to the delivery of medical cover. He reported the proposed changes for delivering care to the elderly had been well received.
- The Topping Out Ceremony was held in Dartmouth, himself, Mrs Davenport, Prof. Balch and Mr Cawley were in attendance alongside local dignitaries and the public. He said the opportunity to collocate the delivery of health and social care was extraordinarily exciting.
- He had met with the League of Friends Chairs; and himself and Mrs Davenport had attended a subsequent meeting with the League of Friends who were seeking ways to increase their footprint and presence within the hospital.
- Options for reinstating Board meetings in person were being considered, with social distancing being borne in mind.

The Board received and noted the report of the Chairman.

85/04/22 **Report of the Chief Executive**

Mrs Davenport, the Chief Executive, presented her report, as circulated, highlighting the following key issues:

- There had been a reduction in number of people with COVID-19 admitted to Hospital and therefore there had been the opportunity to implement the Recovery from COVID-19 planwhich focused on the establishment of the Acute Medical Unit and discharge plan. The Facilities and Estates Teams were commended for their support with the recovery plan which would enable the recommencement of elective care.
- She had attended the Topping Out Ceremony of Dartmouth Health and Well Being Centre, alongside health care and primary care staff and local leaders and highlighted the potential the development had to enable the transformation of delivery of community services to the local population.
- Devon Integrated Care System (ICS) would be formally established on 1 June 2022. The Devon Integrated Care Board (ICB) met in April, she had attended as the Provider Sector Representative.
- The Nightingale Hospital had been supporting Ophthalmology, Orthopaedic, Dermatology and Rheumatology for Royal Devon University Healthcare. Dr Mary Stocker, Consultant Anaesthetist, had been recognised as a key influence between the Trust and the Nightingale Hospital.
- Royal Devon & Exeter Foundation Trust had formally merged with North Devon Foundation Trust. They were now to be known as Royal Devon University Healthcare
- The full OFSTED inspection of Torbay Council's Children's' Services was due to be published on 18 May 2022.
- Jenny Stephens MBE, Chief Officer for Adult Social Care, Devon County Council retired on 1 April 2022. The Board acknowledged and thanked her for the benefit she had brought to the Trust and the Devon Health System as a whole.
- She had been asked to support the interviews for the post of Chief Officer for Adult Social Care, Devon County Council.
- The Mental Health, Learning Disability and Autism Provider Collaborative contract had been signed. The Alliance would work across Northern, Eastern, Western and Southern Devon and within five Local Care Partnership Footprints.
- The NHS Workforce Race Equality Standard (WRES) report was published at the beginning of April. The Trust was awaiting the final report, which the Board to review when available.
- Congratulations were offered to the following Nurses who had received the Daisy Award:
  - Jo White, Midwife;
  - Kate Campbell, Midwife; and
  - Sophie Wells, Trainee Nursing Associate

The Board received and noted the report of the Chief Executive.

Safe Quality Care and Best Experience

86/04/22 **Integrated Performance Report – Month 12, 2021/22**

Ms Jones presented the Integrated Performance Report for month 12, 2021/22, as circulated, and drew the following to the Board's attention:

Quality and Safety

- There were 2 severe incidents and 3 deaths reported through the Strategic Executive Information System (STEIS).
- The stroke performance remained below the 90% target and had deteriorated due to bed pressures.
- Infection Prevention Control measures due to COVID19 and Clostridium Difficile (C-Diff) outbreaks on wards had impacted the operational plan to elevate bed pressures.
- The Ockenden Report had highlighted the relevance of the findings across all services.

Workforce

- The annual rolling sickness absence rate for the end of March 2022 was 5.34%.
- The Trust's annual staff turnover rate was 13.43%; this was within the 10%-14% range, although staff turnover continued to rise.
- The Trust's annual rolling agency figure was £13.24m, £4.9m above plan for the year. Agency spend for March was £1.468m compared to February agency spend of £658k.

Performance

- The Trust experienced a rapid increase of COVID19 patients in March, from circa 20 patients to 71 by 29 March 2022.
- There was pressure in the urgent care pathways which had led to 757 arrivals by ambulance experiencing a delay of over one hour.
- There were 71 patients medically fit with no 'criteria to reside' who required ongoing support and care in community settings. The retention and recruitment of staff remained a significant challenge for the independent sector.
- Levels of unfilled packages of care remained and impacted on patient flow and discharge to the community.
- In March the number of patients waiting over 18 weeks, 52 weeks and 104 weeks continued to increase but a significant improvement in the reduction of waiting lists had been seen in April with Ella Rowcroft providing Elective Care and the re-opening of the Day Surgery Unit.

Finance

- The Trust reported a £1.7m surplus to plan for financial year 21/22.
- The year-end cash position remained strong at £39.3m.

Mrs Davenport focused on the reported high sickness levels and increased agency spend. She asked what progress was being made to recruit into nursing posts and mitigating agency spend. Mrs Kelly explained that March 2022 was a challenged month, with the Trust in escalation. She confirmed a successful recruitment campaign focusing on potential domestic, local and regional staff was underway but acknowledged there was a delay in the process to 'on board' nurses. However, there

was a strong pipeline of international nurses and significant numbers had been welcomed to the Trust. With support of Deloittes who were supporting the ISU's she was confident that in the next quarter, the fill rate would be 95%.

Prof. Balch noted the Urology Department had been moved from the acute site to Paignton Community Hospital, he counselled on the performance benefits if the service embraced digital. Mr Harrison confirmed the Urology Team were now co-located between the acute site, Dawlish and Paignton and acknowledged the logistical challenge of this for the team. Mr Currie advised the long-term plan for the Urology Department would be to be based on the acute site. He explained that in order to attract Consultants into the posts, there was a need for the department to have a clear long-term plan.

Ms Jones confirmed she had asked for monthly scrutiny of the Trust's digital programmes with the trajectory to be presented to Finance Performance and Digital Committee as she believed the Trust's digital engagement and embedding had deteriorated. Part of the Drumbeat Programme would focus on specialities and their level of ambition and ability to digitalise the service.

The Board received and noted the Integrated Performance Report – Month 12, 2021/22.

87/04/22 **Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training**

Mr Currie presented the Report of the Guardian of Safe Working Hours, as circulated, and focused the Board's attention on:

- Mr Ed Berry would step down from his role as the Guardian of Safe Working Hours in August; of new post holder would be appointed.
- The current number of exception reports produced by Junior Doctor's did not present concern.
- It was noted some Junior Doctor's no longer wished to work full time hours and it could present a risk when rostering medical cover.

The Board received and noted the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training

88/04/22 **Maternity Governance and Safety Report (1 January 2022 – 31 March 2022)**

Ms Kelly presented the Maternity Governance and Safety Report as circulated. She brought the Boards attention to:

- The report set out the Trust plans in response to the Ockenden Report.
- The Ockenden Report focused on communication with mothers and with engagement from Healthwatch the maternity department were focusing on their engagement with service users.
- The Ockenden Report would be presented to the Serious Adverse Events Group and learning sought.

Mrs Davenport asked how the Ockenden Report had impacted staff and how they were being supported. Mrs Bassett said herself and Mrs Kelly had met with maternity staff who worked on the acute site and in the community, they are anxious as to what the maternity pathway will be going forward and what women think of the service currently offered. However, staff were keen to be engaged and work collaboratively to support patients. Mrs Taylor reflected on the positive staff moral she had witnessed when she visited the maternity department.

Mr Currie challenged the Board to consider and respond to the wider quality and safety issues and lessons learned from the Ockenden Report. He contextualised how the Trust responds to incidents and patients when teams are clinically isolated.

Mrs Davenport recognised the wider implications of the Ockenden Report and confirmed a Board Seminar Session would be arranged to focus on the Report and how it would resonate with other departments within the Trust. She confirmed the Board work with the Good Governance Institute on the quality and safety agenda.

The Board received and noted the Maternity Governance and Safety Report (1 January 2022 – 31 March 2022)

89/04/22 **Implementation Plan to Achieve Midwifery Continuity of Carer as the Default Model of Care**

Ms Kelly presented the Implementation Plan to Achieve Midwifery Continuity of Carer as the Default Model of Care, as circulated, she brought the Boards attention to:

- The Trust's position in relation to the provision of a default model of Midwifery Continuity of Carer and compliance within the NHSEI Maternity Transformation Programme.
- There was a safe staffing risk associated to this model of care.
- In respect of readiness to implement and sustain the Midwifery Continuity of Carer as the Default Model of Care, the following five areas out of twelve were non-compliant:
  - Safe Staffing
  - Team Building
  - Linked Obstetrician
  - Estate and equipment
  - Review Process

The Board approved the local implementation of the Midwifery Continuity of Carer as the Default Model of Care; and for a quarterly update of the implementation to be provided within the Maternity and Safety Board paper.

90/04/22 **Focus on how infection prevention and control measures for COVID-19 are developing for Living with COVID-19**

Dr Watson presented the Focus on how infection prevention and control measures for COVID-19 are developing for Living with COVID-19 as circulated. She drew the Boards attention to:

- Due to the success of the COVID-19 vaccination programme people were presenting with a mild to moderate viral infection.
- NHSEI guidance had been disseminated; and Dr Watson advised there needed to be a balance between the national guidance, living with COVID-19 and managing COVID-19 infection transmission within the Hospital.
- Medical staff were being consulted as there was a need to manage infection spread as well as managing patient flow. There would be further consultation with Trust staff at CMG on 28 April 2022.
- NHSEI Guidance proposed COVID-19 surveillance was undertaken at Ward level, this was not considered efficient.
- She informed the Board of the risk of harm to patients who may catch COVID-19 whilst in the Trust's care.

Mrs Davenport acknowledged the difficult position of balancing optimal capacity for elective work and ensuring patients were not placed at unnecessary risk.

Mr Sutton supported the need for infection spread being managed alongside patient flow and asked for communication with care and community settings, which would instil confidence and enhance flow. Dr Watson confirmed she was engaged with the local care sector in that regard.

Mrs Kelly highlighted the need for clear communication internally and externally when the Board had approved the guidelines. The Chairman believed if the guidelines were to be varied at the Trust discretion staff must be aware it would be a Board mandated change.

The Chairman agreed an out of committee decision could be made on the NHSEI Guidance on infection prevention and control measures for COVID are developing for Living with COVID.

The Board received and noted the Focus on how infection prevention and control measures for COVID are developing for Living with COVID

Valuing our Workforce

91/04/22 **2021 National NHS Staff Survey Report**

Mrs Falcao presented the 2021 National NHS Staff Survey Report as circulated. She drew the Boards attention to:

- A deterioration in the response rate benchmark against the national average but, the Trust had reported an improved overall response rate of 46% of staff completing the survey.
- The following themes were drawn from the survey and aligned to the Freedom to Speak Up Guardian Report:
  - The feeling of being unable to undertake a role well due to lack of resource;
  - The Health and Well Being Offer;
  - Recruitment, retention and talent management; and
  - Patients bullying and harassing staff.
- The need to share the learning from experiences.

- The importance of the appraisal process and the quality of the conversations to understand how staff felt and working together with the support of managers.
- It had been agreed the ISU breakdown of the Staff Survey would be discussed with the individual ISU leadership teams and their Organisational Development Business Partner would support them.

Mrs Davenport reflected on the important opportunity the Staff Survey offers to reflect on the messages from staff. She said there were some clear messages within the survey about how staff's experience of work that needed to be addressed. She requested that the People Committee undertook to focus on the Staff Survey messages. Mrs Matthews confirmed the People Committee would focus on the priorities and messages identified.

Mrs Matthews highlighted the need for the Trust to focus on talent retention. She said the Trust needed to make it attractive for staff to return after leaving to acquire new skills, like Mr Bradley.

Prof. Balch reflected on the good initiative that had been undertaken in respect of bullying and harassment but acknowledged it was still an issue and that the initiatives needed to be embedded.

Mrs Matthews and Prof. Balch proposed the Trust focus on a few high priority themes that had the capacity to be delivered and embedded into the Trust's core business.

Mr Currie asked for an overview of what positive themes ran through the Staff Survey and proposed the Trust draw on the high functioning teams and seek learning to support those teams that had negative themes.

The Board received and noted the 2021 National NHS Staff Survey Report.

92/04/22 **Equality, Diversity and Inclusion**

Mrs Falcao presented the Equality, Diversity and Inclusion Report as circulated. She drew the Boards attention to:

- The Equality Diversity and Inclusion priorities are being embedded into the People Plan.
- The need for all Black, Asian and Ethnic Minority (BAME) staff to undertake risk assessment during COVID-19 provided the Trust with the opportunity to connect with them and offered an opportunity for an open dialogue and wider conversations taking place.
- The BAME Network as a system, was undertaking to understand the barriers to career progression linked with cultural differences and considering how all staff can be offered the same opportunities.

Mrs Davenport noted the strong evidence that organisations who are good at engaging with their diverse workforce provide better clinical outcomes for their patients. She acknowledged the positive impact the Equality, Diversity and Inclusion Agenda was having across the Trust.

Ms Kelly highlighted the support Ms Edworthy and Ms Simadree had offered the wards around the Equality, Diversity and Inclusion Agenda and acknowledged the further support that was needed around the Equality Diversity and Inclusion Agenda.

Mrs Matthews acknowledged the Board's commitment to the Equality Diversity and Inclusion agenda and the work undertaken by Ms Simadree in that regard.

The Board received and noted the Equality, Diversity and Inclusion Report.

93/04/22 **Talent Management Update**

Mrs Falcao presented the Talent Management Update as circulated. She drew the Boards attention to:

- The Talent Management Project commenced pre-COVID-19 and as per Board agreement, was on the ICS Chief People Officer's meeting agenda.

Mrs Matthews counselled on the need for a framework that people could navigate through during their careers. She reflected on the need to strike a balance between an organic framework and one that was inclusive for all.

Mrs Davenport explained that succession planning would be critical to getting the nationally mandated health ambitions correct and this needed to be at the centre of the talent management system.

The Board received and noted the Talent Management Update.

94/04/22 **Electronic Patient Record (EPR) Outline Business Case (OBC)**

Ms Jones presented the Electronic Patient Record (EPR) Outline Business Case (OBC) to the Board, as circulated. She drew the Board's attention to:

- The OBC with the support of conversation with the Regional Team and the Peninsula was going to the joint investment committee, with a focus on collaboration to drive efficiencies and benefits.

The Board received and noted the Electronic Patient Record (EPR) Outline Business Case (OBC).

95/04/22 **Compliance Issues**

There were no compliance issues reported.

96/04/22 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

97/04/22 **Date and Time of Next Meeting:**

11.30 am, Wednesday 25 May 2022.

Exclusion of the Public

It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
	No actions outstanding			

NHS
Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Parking Lot **Reviewed: 1st February 2022**

Item/action/issue/policy name	Meeting Date	Comment
Standing Orders, SFI's Report	26th January 2022	Deferred to 29th June 2022

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 25 May 2022
Report appendix	Board assurance framework summary Integrated Care System for Devon update for Boards		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 17 May 2022		
Purpose of the report and key issues for consideration/decision	To provide an update from the Chief Executive on key corporate matters, local system and national initiatives and developments since the previous Board meeting.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Chief Executive's Report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	
Risk Register	X	**Risk score**	

- BAF objective 1: to develop and implement the Long-Term Plan with partners and local stakeholders to support the delivery of our ICO Strategy - risk score 20
- BAF objective 10: to actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on our reputation - risk score 9

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS Improvement	X	**Legislation**	
NHS England	X	**National policy/guidance**	X

Report title: Chief Executive's Report		Meeting date: 25 May 2022
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our vision and purpose

Our vision is better health and care for all. Our purpose is to support the people of Torbay and South Devon to live well.

2 Our strategic goals and our priorities

Our strategic goals and priorities have been set to help us achieve our purpose and our vision.

Our strategic goals are:

- excellent population health and wellbeing
- excellent experience receiving and providing care
- excellent value and sustainability

Our priorities are:

- more personalised and preventative care: what matters to you matters
- reduce inequity and build a health community with local partners
- relentless focus on quality improvement underpinned by people, process and technology
- build a healthy organisational culture where our workforce thrives
- improve access to specialist services through partnerships across Devon
- improve financial value and environmental sustainability.

This report is structured around our strategic goals to help us measure our progress, address our challenges and celebrate our successes.

3 Our key issues and developments

Key issues and developments to bring to the attention of the Board since the last Board of Directors meeting held on 27 April 2022 are as follows:

3.1 Excellent population health and wellbeing

CQC/Ofsted inspection of services for children with special educational needs and/or disabilities in Devon County

Ofsted's Inspection of Local Authorities Childrens Services (ILACS) will take place between 23 and 25 May 2022.

Joint area SEND inspection in Torbay – Written Statement of Action (WSOA)

Torbay Council and Devon Clinical Commissioning Group have received confirmation that following submission of the WSOA on 14 April 2022 it has been

approved by Ofsted. The WSOA was published on Torbay Council's website on Friday 6 May 2022 and can be accessed via www.torbay.gov.uk/send-report

Ofsted recognised that the WSOA…
'covers the eight areas of significant weakness that were identified in the published report. You have made clear the agreed roles and responsibilities of the named officers in each pillar of the plan. This comprehensive approach shows that the local area is committed to working jointly with the clinical commissioning group and a range of partners and stakeholders including schools, health services and social care'.

Ofsted further commented…
'I am pleased to see the involvement of parents and carers, children and young people in the development of this statement of action. You demonstrate your commitment to the coproduction of services. You understand the dissatisfaction with services felt by many families. By recognising this you establish a sound baseline for future improvement.'

The partnership will now be progressing implementation and are determined to make rapid.

Torbay Children's Services rated as good by Ofsted inspection
An Ofsted inspection of Torbay's Children's Services took place between 21 March to 1 April 2022.

Ofsted have judged the Council as 'Good' in all four areas of inspection
- the impact of leaders on social work practice with children and families.
- the experiences and progress of children who need help and protection.
- the experiences and progress of children in care and care leavers.
- overall effectiveness.

The report confirms that "services for children in Torbay have significantly improved" and that this is an "impressive achievement", recognising that services are making a real difference to the lives of children and young people.

After receiving an 'Inadequate' rating following the last two inspections and years of underperforming historically, the report acknowledges the "remarkable transformation". They attribute this change to a clear and ambitious improvement plan, based on evidence of what was causing long-standing, inadequate practice in Torbay, together with a strong political and corporate commitment to the improvement agenda.

Recruitment of new Chief Officer for Adult Care and Health, Devon County Council
Interviews for the new Chief Officer for Adult Care and Health, Devon County Council, will take place on 25 May and I will be involved in the interview process.

Place-based leadership in Torbay
We are working with Torbay Council towards a different leadership approach across Torbay which is focused on place. This means that those organisations who have decision-making power strive to improve the quality of life of communities living in the place.

The role of the place board is to bring those organisations, and the individuals that lead them, to a space which encourages holistic thinking about how we can influence and deliver better outcomes for people in our communities.

Our focus is on identifying better or new approaches across our organisations, working together, learning together and creating distinctive and authentic solutions that work for Torbay.

It will also give us the opportunity to leverage the 'levelling up' offered by the Devon local deal to further improve outcomes for our communities.

Community wealth building in Torbay
We are proud to have signed a community wealth building memorandum of understanding to work together with public sector partners across Torbay to support local economic growth.

In partnership with Torbay Council, South Devon College and the Torbay Development Agency we have pledge to spend more with local companies where possible. We want to use our financial powers more effectively to help benefit the local economy and create new employment and training opportunities for people.

This speaks directly to our priorities of reducing inequity and building a health community with local partners and improving financial value and environmental sustainability.

3.2 Excellent experience receiving and providing care

Current pressures
The number of patients with COVID-19 in our hospitals has significantly reduced and we have been able to relocate our day surgery unit to its usual home and progress our elective recovery.

Sickness absence across all our services remains high despite the fall in the number of COVID-19. Demand for our services remains very high across acute, community and social care.

Key areas of focus are minimising ambulance handover delays and reducing the number of people waiting for two years for treatment (104 week waits). We have begun to reduce our ambulance handover delays, however, there continue to be far too many occasions when ambulances are queuing outside our Emergency Department. All patients who arrive at our Emergency Department are triaged and assessed, with the most clinically urgent being prioritised.

We know that people have been waiting far too long for treatment, care and surgery. We have contacted the majority of people on our waiting lists who will have been waiting for more than 104 weeks by the end of June. A small number have chosen to take up the offer of treatment at an alternative provider. With in-sourcing coming on stream shortly, our day surgery unit back in its usual home and Ella Rowcroft ward operational, we are slightly ahead of plan.

Patients who fit the criteria for orthopaedic surgery at the Southwest Ambulatory Orthopaedic Centre at the Nightingale Hospital Exeter are being offered treatment there and the feedback received from patients to date has been very positive. We also continue to offer people waiting for diagnostics the opportunity to have their scan at the Nightingale Hospital Exeter and encourage everyone to take up the offer if they are able to do so.

Every number on our waiting lists is a person whose quality of life is being affected by their wait and we are committed to working together with our partners to do everything we can to reduce our waiting lists and make sure that people get the care they need when they need it.

From 12 May, people staying in our hospitals have been able to have two visitors at their bedside. Visitors no longer have to book a slot to visit and visiting hours are 2pm-4pm and 6.30pm-7.30pm. People attending outpatient services can be accompanied by one person if they would like support. Separate arrangements are in place in our maternity and childrens services.

Supporting children and young people's mental health while in hospital
Children and young people admitted to Torbay Hospital are benefitting from new equipment and aids to support emotional wellbeing. By providing younger patients with access to items such as weighted blankets, a 'magic carpet' interactive floor projector, YoTo players and other audio visual, tactile and sensory equipment we can reduce their stress, improve their wellbeing and give them a better experience of being in hospital.

Our paediatric teams recognise that the more we can do now, to improve our children and young people's health and wellbeing, the bigger difference it will have for their future. The World Health Organisation calls this the triple dividend – improving health now, building better health for adulthood and contributing to the health of future generations.

Dr James Dearden, Consultant Paediatrician and Paediatric Mental Health Lead, has worked with colleagues to establish a paediatric mental health network (launched in February 2022) to share good practice, explore ideas for improvements and provide peer support and training. Good local networks have been established with children's social care, child and adolescent mental health services and local schools to work together to raise awareness of issues affecting children and young people, provide education and support and to work towards a culture change that ensures parity of esteem for physical and mental health.

The Child Health team has also been successful in securing a place in October 2022 on the roll out of the national Health Education England for *We Can Talk* training programme, a crisis mental health training package for staff in acute hospitals. The training will add to their plan around improving our mental health support to children and young people who are admitted to hospital.

Celebrating international midwives day and international nurses day
We held six days of celebration for our midwives, nurses, students and nursing support staff with lots of activities and events across our community and acute services and sites.

Nina Henton, one of our nurses who is also a participant in the Florence Nightingale Foundation scholarship was invited to represent us at the service to commemorate the life of Florence Nightingale which held at Westminster Abbey on 11 May while Christina Harrison, a nurse in our Emergency Department shared her journey as a change agent on the NHS Big Conversation Improvement event.
We also held a very successful 'aspire to be' recruitment event for people considering becoming health care support workers on international nurses day. We recruited over 30 people on the day and look forward to welcoming them to our Torbay and South Devon family.

Ockenden interim report
Following the publication of the Ockenden report into Maternity Services all NHS providers of maternity services were asked to provide assurance across a number of areas of their services. You will recall that we reported to the Board of Directors on this matter in January this year and outlined the progress that we have made.

On 19 May NHSE/I Board of Directors will consider a detailed breakdown of returns by trusts on their progress against the seven Immediate and Essential actions (IEAS) set out in the interim Ockenden report. The returns will form part of their Board papers which will be published online shortly.
We have fully taken on board the interim Ockenden's report's recommendations, we have developed comprehensive action plans and good progress has been made.

We have been assessed as fully compliant in five of the seven IEAs and partially compliant in two. The two partially compliant areas are:

- **Listening to Women and their Families** - have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
- **Risk Assessment throughout pregnancy** - a risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

We have reviewed how we listen to and act on feedback from women, pregnant people and their families to make a number of improvements. A key part of this is taking place through the Maternity Voices Partnership (MVP) - a NHS working group where women, pregnant people and their families, commissioners and providers (midwives and doctors) work together to review and contribute to the development of local maternity care.

We have experienced a gap in local representation from the MVP, however, please be assured that this is being resolved and we have begun much closer engagement with our MVP through monthly meetings and a joint action plan. We are also exploring other ways to collaborate and directly engage with local women, pregnant people and their families and we have a dedicated Facebook and Twitter page.

In relation to the second action concerning the element of risk assessment, risk assessments have, and are being, carried out at every contact. However, what has been difficult to evidence is a mechanism to record these and audit this compliance. We now have a new digital maternity record (System 1) which was introduced at the beginning of May so we will continue to audit each person's record in order to ensure the risk assessments are completed.

We will continue to monitor all areas of progress though our governance forums. We are already seeing improvements in terms of the recruitment and retention of midwifery staff and we are confident, that as we continue on our planned trajectory, we will achieve our aim of full midwifery establishment by the end of this year.

I would like to take this opportunity to thank all our maternity staff for their absolute commitment to providing the best possible service for local women, pregnant people and their families.

Improvement and innovation strategy
On the day of our Board meeting we will be launching our Improvement and Innovation strategy which aims to create the conditions to build improvement capability in all of our people. The focus of the strategy is on generating the capacity to innovate, to make big audacious ideas happen and the capacity to continuously improve, to see the things in our work that can be even better and develop the skills in our people to make it happen.

Our Improvement and Innovation team will be delivering improvement boxes to our teams that will be filled with lots of resources to help build awareness about 'our ICO Way', putting improvement expertise at the heart of everything we do. I understand that our teams will also find some surprises in their boxes too.

Our People Awards winners – April 2022
At our April Trust Talk we announced our first Our People Awards winners. The awards presentations will be taking place over the next few weeks. The winners are:

We are a team
- Junior Doctors Representative Committee

We are always learning
- Healthy Living Programme for Type 2 Diabetes, St. Edmunds

We are safe and healthy
- Della Holwill and Emily Cooper, Community Dietitians

We work flexibly
- Shelia Needs, Liver Specialist

We each have a voice that counts
- Lauren Bone, Torbay Health Visiting and School Nursing

We are compassionate and inclusive

- James Reed, Radiology

Chair's Special Award

- COVID-19 and flu vaccination team, Torbay Hospital

Nominations are now open for the next round of Our People Awards. Nominations remain open for our annual People's Choice Awards (Our People Awards - Torbay and South Devon NHS Foundation Trust) and our annual People Partner Award.

Devon and Cornwall (Peninsula) Paediatric Awards For Training Achievements (PAFTAs)

Three of our people and one of our teams won awards at the Peninsula PAFTAs held on 14 May. Our winners were:

Allied Health Professional of the year: Beth Young, Physician Associate

Senior hero and first recipient of the Kate Westwood Memorial Award (Paediatric Trainees/SAS/Speciality/Staff Grade and other doctors at registrar level): Jemma Baker

Nursing role model: Debbie Bourne, Staff Nurse

Team of the year: Louisa Cary ward shared the award with four other teams

Ward accreditations

During April 2022, four more of our wards were assessed under the scheme.

Dawlish community achieved a silver award on their very first assessment.

Allerton ward achieved a gold award. This is a tremendous achievement as they have gone from bronze, to silver, to gold in the last eight months and their improvements can be very much seen and felt – this is a testament to Becky Smith and her leadership of the ward.

Cheetham Hill achieved a gold award. This was an improvement on their last assessment when they received a silver award.

Simpson ward achieved a gold award. This is their second gold and they have maintained their accreditation while undergoing a change in leadership which is great testament to the ward team.

DAISY awards

For April 2022 our DAISY award winner is Maggie Traynor, midwife. Maggie was nominated by a woman she had supported. The nomination is below:

"I was in and out of the Maternity unit in the last trimester of pregnancy due to unexplained bleeds. Maggie was just amazing every time I saw her. I would hope and pray she would be on duty when I had to go in for checks. She was so personable and loving and caring. Felt like I had my mum there with me! She went out of her way to make me feel comfortable and explain things to me. She

helped me advocate for myself against consultants. What an amazing woman and an amazing team of women. Pregnancy is such a vulnerable time in life. I am so grateful for all the support I was given. Torbay you should be so proud of your midwifery team they are all absolute angels."

As advised in my April report, Kate Campbell, midwife, won our DAISY award in February 2022. It was the second time Kate has won a DAISY award. She was nominated by a woman she had supported. The nomination is below:

"Kate was amazing throughout my post-natal birth and antenatal journey. Having had a few issues with my previous births and breast-feeding journeys Kate made certain that she was fully aware and went above and beyond to reassure me and avoid these issues reoccurring.

For example, I spoke to Kate about how my previous c-section felt clinical and that I felt like a number with no familiar healthcare professionals. Kate swapped her shifts to ensure that she was our midwife at our son's birth. This really meant a lot to me. I felt Kate knew our background journey and that we were in really safe hands.

Kate was also aware of the feeding issues we had with our eldest son: namely latch and mastitis which led to sepsis. Kate diagnosed our son with a tongue tie before we even left the delivery suite which meant that we were able to quickly seek advice and treatment; our breast-feeding journey so far has been successful and I feel Kate's support has been paramount to this.

In addition, Kate made herself available for our day one newborn check so that we could see her instead of an unknown midwife at the planned clinic. I spoke to Kate prior to the newborn check and asked how I could retrieve personal belongings that I left behind at the hospital. Kate said that she would check whether they had been found; however, she went many steps further by retrieving our lost property from Torbay hospital and then bringing them to our newborn check at Newton Abbot hospital.

These actions could be perceived as small but they made me feel grateful appreciative and gave me a 'warm feeling'. Kate is a truly amazing devoted midwife and I feel so lucky to have been supported by her throughout our pregnancy journey."

Our League of Friends

We are delighted to be able to start welcoming back our League of Friends volunteers across our acute and community hospital sites as we learn to live with COVID-19. We are making good progress with a dedicated space for Torbay Hospital League of Friends in the main entrance on level 4.

Torbay Hospital League of Friends are holding an UnMasked Ball on 02 July 2022 to raise funds to purchase equipment and enhance the environment in the new Acute Medical Unit currently under construction. Tickets are available at: The Unmasked Ball Tickets, Sat 2 Jul 2022 at 18:30 | Eventbrite

3.3 Excellent value and sustainability

Torbay's first solar park approved

We welcome the important step forward in the development of Torbay's first solar park (approved at Torbay Council's Planning Committee earlier this month) and will continue to work closely and collaboratively with our Torbay Council partners as the plans progress.

Should the scheme progress this sustainable energy source would contribute to our green plan and increase the amount of renewable energy we use, which would bring benefits to our local communities. The NHS nationally has committed to reaching net zero carbon emissions, and it is green initiatives and innovations like this that will help us achieve our ambitions.

Dartmouth health and wellbeing centre

At the end of April we celebrated reaching the highest point in the construction of the Dartmouth Health and Wellbeing Centre with a topping out ceremony.
Along with our Chairman, Sir Richard Ibbotson, I was joined by representatives of local staff, South Hams District Council, Dartmouth Town Council, Dartmouth League of Friends, Dartmouth Caring, Dartmouth Medical Practice, local Governors and the CCG.

The development, which will provide a brand-new centre for community services alongside the GP practice, a pharmacy and voluntary services, will open later this year.

Redevelopment of the former Dartmouth and Kingswear community hospital site

We continue to work closely with Dartmouth Town Council to explore a community-led bid for the former community hospital site and we hope to be in a position to make an announcement next month.

Teignmouth Health and Wellbeing Centre

At the end of April, Teignbridge District Councillors approved the sale of the town centre land in the town's Brunswick Street to for a new Health and Wellbeing Centre for Teignmouth.

We are now finalising terms with the aim of submitting a planning application as soon as possible. The Health and Wellbeing Centre will house a number of services including intermediate care, community therapies, podiatry and audiology alongside the Channel View Medical Group.

Marking the Queen's Platinum Jubilee

Throughout her 70 year reign Her Majesty Queen Elizabeth II has shown exceptional leadership and given us an unrivalled example of service and dedication.

Along with other NHS organisations across the country, we are proud to be marking her Platinum Jubilee. Staff across our services are arranging celebrations and activities for patients and colleagues and our fantastic catering team in the Bayview restaurant at Torbay Hospital will be offering a special menu.

4. Chief Executive engagement May

I have continued to engage with external stakeholders and partners – in the main with the aid of digital technology. Along with the executive team, I remain very conscious of the need to maintain direct contact with our staff, providing visible leadership and ongoing support, as our teams continue to strive to deliver excellent care during exceptionally challenging circumstances across all our services.

Internal	External
• Video blog sessions • Diversity & Inclusion Lead • Visit and Staff Heroes Presentation to Day Surgery Unit • Medical Staffing Committee • Lead Governor meetings • League of Friends • Dartmouth Topping & Tailing	• Chief Executive, Integrated Care System for Devon (ICSD) • Deputy Chief Executive, Devon Clinical Commissioning Group • Long Term Plan Programme Director, ICSD • Improvement Director, NHS England and NHS Improvement (NHSEI) • Devon Engagement Event • National Leadership Event with Devon Chief Executive Officers (CEOs) • Medical Director, LiveWell SouthWest • Chief People Officer, Interview Panel, Devon Partnership NHS Trust • Chief Executive Officer and Councillor, Torbay Council • Director of Children's Services, Torbay Council • Torbay Place Based Leadership Board • Devon NHS CEOs Meeting • South West Regional Chief Executives • Strategy Transformation and Improvement Director, NHSEI • Chief Executive Officer, HealthWatch Torbay • Principal and Chief Executive Officer, South Devon College • Anne-Marie Morris MP • Kevin Foster MP • South West Regional Medical School Liaison Committee Meeting

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System developments

Work is underway by the Integrated Care System (ICS) Development Programme to strengthen collaborative working and support people and communities.

Please see the ICSD update for Boards appended to this report.

6 Local media update

6.1 News release and campaign highlights include:

We continue to maximise our use of local and social media as well as our website to ensure that the people of Torbay and South Devon have access to timely, accurate information, to support them to live well and access services appropriately when needed.

Since the April Board report, activity to promote the work of our staff and partners has included:

Recent key media releases and responses:

- Surgical services at NHS Nightingale Exeter benefitting people in Torbay and South Devon – following the opening of the elective care centre at Nightingale, we published a release which shared experiences from Torbay and South Devon residents
- Positive feedback for maternity services in national survey – sharing great news about positive feedback received from families as part of a Care Quality Commission national survey
- Carers Week 2022 activities and events – promoting opportunities for unpaid carers in Torbay to sign up to events and activities taking place during Carers Week in June
- Living with COVID-19 article – Dr Joanne Watson, Director of Infection Prevention and Control, had an article in Torbay Weekly on why restrictions remain in healthcare settings and what local people can do to support their NHS

Recent engagement on our social media channels includes:

- National Siblings Day – thanked all the siblings working across our organisation and shared a photo of two sisters who work closely together as part of our fantastic team on Forrest Ward at Torbay Hospital
- Maternity services going paperless – promoted the use of our new maternity system which means families will be able to access information and advice from a new app
- Healthy futures – promoted the latest and previous editions of our Healthy Futures stakeholder newsletter
- National Pet Day – emphasising the physical and mental health benefits that pets can bring us, and asked our followers to share photos of their much-loved companions

- HOPE programme for NHS staff – promoted an upcoming self-care, self-management HOPE Programme course which is exclusively available for our staff
- Healthcare support worker recruitment event – advertising our upcoming recruitment event for healthcare support workers, for people new to care or with experience
- Think 111 – encouraging the use of NHS 111 for urgent, non-life-threatening conditions in order to get help from the most appropriate service ahead of the bank holiday weekends
- Transforming patient care webinar – promoted a webinar featuring members of our digital futures programme who have been doing amazing work using immersive technologies in education and clinical practice
- Cervical screening reminders – using national resources to highlight the importance of attending your regular cervical screening check

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 30 April 2022
LinkedIn	5,000 followers	2,878	4,081 ↑ 1,203 followers
Facebook	15,000 likes	12,141	12,896 ↑ 755 followers
	15,000 followers	12,499	13,393 ↑ 894 followers
Twitter	8,000 followers	6,801	7,429 ↑ 628 followers

7 Recommendation

Board members are asked to **receive and note** the report and **consider** any implications on our strategy and delivery plans.

BOARD ASSURANCE FRAMEWORK SUMMARY

Q1 2022/23 v01

Ref	Executive Owner	Corporate Objective	Current risk	Target risk	Strength of Controls	Strength of assurance	Executive Comment
1	Liz Davenport Chief Executive	To develop and implement the Long Term Plan with partners and local stakeholders to support the delivery of the Trust's strategy	20	16	Amber	Amber	
2	John Harrison Chief Operating Officer	To deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care and best experience	20	20	Red	Red	
3	Dave Stacey Chief Finance Officer	To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care	16	16	Amber	Amber	
4	Deborah Kelly Chief Nurse	To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19	20	16	Amber	Amber/Red	
5	Dave Stacey Chief Finance Officer	To provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times	25	16	Amber	Amber	
6	Adel Jones Director of Transformation & Partnerships	To provide and maintain a fit for purpose digital infrastructure ensuring service continuity at all times	25	25	Red	Red	
7	Adel Jones Director of Transformation and Partnerships	To implement the Trust plans to transform services, using digital as an enabler, to meet the needs of our local population	20	12	Amber	Red	Updates to reflect current position and current risk score increased from 16 to 20
8	Judy Falcao Chief People Officer	To implement and continuously review the Trust People Plan, ensuring the Trust is a '*great place to work*'	16	12	Amber	Amber	
9	Judy Falcao Chief People Officer	To ensure management practice, leadership capacity and capability to deliver high-quality, sustainable care for the local population	16	12	Amber	Amber	
10	Liz Davenport Chief Executive	To actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on	9	9	Amber	Amber	
11	Adel Jones Director of Transformation & Partnerships	To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring it meets the needs of the local population and the Peninsula System	16	12	Amber	Amber	Updated to reflect amendments agreed at the last BBF Committee meeting

Integrated Care System for Devon (ICSD) Update for Board and Cabinet members

May 2022

The purpose of this regular report is to:

- **Provide a monthly update for Board, Cabinet and Governing Body meetings across ICS partner organisations in Devon, Plymouth and Torbay.**
- **Ensure everyone is aware of ICS developments, decisions, issues and news in a timely way.**
- **Ensure consistency of message amongst ICS partner organisations.**
- **Accompany your own briefings to Board, Cabinet and Governing Body meetings. If cutting/pasting content, can this please be done in its entirety.**

This update features:

1. **Health and Care Act receives Royal Assent**
2. **Mental Health, Learning Disability and Autism provider collaborative update**
3. **Workforce Strategy update**
4. **New mental health work already benefitting local patients**
5. **Nightingale benefitting patients across Devon**
6. **Devon and Cornwall Care Record update**

1. Health and Care Act receives Royal Assent

The Health and Care Act 2022 has completed the parliamentary process and received Royal Assent, marking a milestone in the recovery and reform of health and social care services.

This is a welcome and important step on the journey towards the establishment of statutory Integrated Care Systems which comes into effect on 1 July 2022. From this date Integrated Care Systems will move onto a statutory footing with the establishment of Integrated Care Boards and Integrated Care Partnerships.

This Act will ensure our health and care system emerges stronger from the Covid pandemic. The challenges currently faced by the NHS, local authorities and other partners as we recover from the pandemic are huge. This comes on top of the long-term challenges we face as a country; a growing and ageing population, chronic conditions and inequalities in health outcomes. We are putting in place measures to help people live longer, healthier lives and to create a framework for us to build a

Together for Devon

Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

safer, stronger and more joined up health and care system that delivers better outcomes for everyone. The Act aims to develop a more seamless health and care service and improve population health, building on several years of practical experience and innovation across the health and care system.

It ensures that every part of England is covered by an Integrated Care System, bringing together NHS, local government, social care providers, charities, and voluntary, community and social enterprise partners to jointly plan and provide health and care services based on the needs of the people in their areas.

Preparatory work to establish Integrated Care Systems and transition to statutory status has been ongoing for some time. This work will continue up to 1 July 2022 when the new arrangements will formally be established and Clinical Commissioning Groups will be abolished.

2. Update: Mental Health, Learning Disability and Neurodiversity Provider Collaborative

Provider Collaboratives are to be a key component of system working, helping providers to work together to plan, deliver and transform services. By working at scale, Provider Collaboratives provide opportunities to tackle unwarranted variation in care, make improvements and deliver the best care for people using services and the wider communities they serve.

Devon's Mental Health, Learning Disability and Neurodiversity (MHLDN) Provider Collaborative will allow system experts to more effectively target and deliver high quality, safe, efficient and effective care – reducing duplication of effort and driving improvements. This will be achieved through delivery of co-produced, integrated models of care alongside the clinical and professional voice. Co-production with lived experts, people who use services, their carers and expert partners (Voluntary, Community and Social Enterprise sector) will be pivotal to the design and delivery of these care models.

Objectives of the collaborative are:

The MHLDN Provider Collaborative leadership team has developed outline plans for delivery of programme from July 2022.

As Accountable Provider for the MHLDN Provider Collaborative, Devon Partnership NHS Trust (DPT) will have very clear responsibilities for the commissioning and delivery for high quality care, set out in an agreed scheme of delegation from the ICB. For further information, contact:

- Jacquie Mowbray-Gould Programme Director, jmowbray-gould@nhs.net
- Dr Colm Owens, Clinical Director, colmowens@nhs.net

3. Workforce strategy update

Work continues on the development of the Integrated Care System for Devon workforce strategy.

Five principles to inform the strategy have been drafted and are currently being shared for initial review with key executive, clinical and workforce stakeholders across all system partners.

Once formally approved, the five principles will form the basis for further engagement and stakeholder workshops to discuss and explore the future workforce models, skills and role diversity required to meet the increased demand and activity for health and care services over the coming years.

The ICS workforce team have undertaken their Operational Planning for 2022/23 in collaboration with system partners and have identified their priorities and workstreams for 2022/23.

These priorities and workstreams will be delivered through four Devon People Plan Delivery Pillars, each one being led by an executive senior responsible officer from the system's Human Resources Director community.

The four delivery pillars are:

- Best Place to Work
- Workforce Strategy & Planning
- Learning, Education & Development
- Workforce Transformation & Planning

The Devon People Plan is scheduled to be approved by the People Programme Board in May and will be shared with board members in June.

System partners are working together to review the outcome of the recent NHS staff survey and agree actions to tackle the issues identified and a further update on actions and outcomes will be provided in due course.

4. Community Mental Health Framework already benefitting local people

The new Community Mental Health Framework is already making a difference to local people. Mental health colleagues across Livewell Southwest and Devon Partnership NHS Trust play an important role in implementing the framework and are working with local partners to join up services and provide timely care.

One such role is the Mental Health Practitioner – these colleagues are helping to connect primary care and core mental health services. They also provide direct advice, guidance, assessment and intervention when appropriate to people with severe mental illness and to those who may currently in the gap between services.

For example, Racheal Prior, a Senior Mental Health Nurse working in the Primary Care Mental Health (PCMH) Team at Livewell Southwest, splits her time between GP practices, taking calls to support and assess people and working with her PCMH Team on assessments that have come into the team. A main focus is on ensuing people are referred to the right team or, short-term intervention from her team.

Racheal, who works alongside the Waterside Health Network in Plymouth, said: “It means people aren’t just waiting long periods of time or bouncing around the system but looking at what can we put in place to support them to enable their recovery. This not only supports and empowers them, but it also helps cut some of the uncertainty they have while they wait.”

Stephen Bates, Primary Care Network Manager for Waterside Health Network, added: “This work is a really big advancement in primary care mental health and it’s so important that we work together to get it right for the people we support.”

Becky is one of Racheal’s former patients. The 27-year-old had pre-existing mental health issues which were well managed. However, as a result of the pandemic and losing her job, Becky started to experience blackout episodes where she had no memory of what she had done or said which triggered the Schizotypal Personality Disorder she was diagnosed with at 19. Racheal worked with Becky to come up with options to try and support her while under her care and looked at what long-term support she might benefit from.

Becky said: “Racheal’s support has made me feel like I have some control back and that I can cope more and more each day. She really went the extra mile to support me and has given me confidence in myself to feel like I can trust myself to join back in society fully at some point.”

5. Nightingale benefitting patients across Devon

New surgical services at the NHS Nightingale Exeter are already benefitting people across Devon

The NHS Nightingale Exeter is now offering a range of orthopaedic, ophthalmology, diagnostic and rheumatology services to local people, helping to further reduce waiting times for people who have had surgery delayed due to the COVID-19 pandemic.

After being decommissioned as a COVID-19 hospital in March 2021, the Nightingale was bought by the Royal Devon University Healthcare NHS Foundation Trust on behalf of NHS organisations across Devon and the South West region. After a clinically-led transformation, it is now home to the following services:

- Southwest Ambulatory Orthopaedic Centre (SWAOC), which has two operating theatres for day case and short stay elective orthopaedic procedures

- Centre of Excellence for Eyes, which operates diagnostic screening services for ophthalmology patients and will run a high-volume cataract treatment hub
- Devon Diagnostic Centre, which is providing CT, MRI, X-ray, ultrasound, echocardiograms and fluoroscopy services
- The Royal Devon and Exeter Hospital's rheumatology department which provides outpatient care and day case infusions.

The Chair of Devon's Planned Care Board, Suzanne Tracey, said: "The NHS Nightingale Hospital Exeter is an invaluable resource for those living across the South West, offering protected elective capacity to address waiting lists in services that have been particularly impacted by the Covid-19 pandemic.

"The Nightingale is already helping us to reduce waiting times and is making a real difference to the lives of people living across the South West. Half of patients having hip or knee surgery returned home the same day and all were home by the following day; making NHS Nightingale the best of its kind for day case rates in the UK."

NHS trusts in Devon are working together to offer patients from their local areas appointments at Nightingale. Feedback from people who have been treated there has been very positive and among the first patients to have received treatment at the facility are those from the Exeter, North Devon, Torbay and South Devon areas.

Dr Mary Stocker, Clinical Lead for SWAOC and Consultant Anaesthetist at Torbay and South Devon NHS Foundation Trust, said: "It is wonderful to hear our patients' positive feedback about their experience. SWAOC will significantly benefit people in Torbay and South Devon, many of whom, like people all over the country, have been waiting a very long time for surgery."

6. Devon and Cornwall Care Record update

Health and care partners are working together to deliver a new system called the Devon and Cornwall Care Record that will transform the way we provide services to patients.

The Devon and Cornwall Care Record enables authorised health and care staff to see details held by a wide range of health and care providers across Devon, Cornwall, and the Isle of Scilly in a single record - giving them a more complete view of a patient's history. It is part of a national programme to transform information sharing across health and social care and comprehensive plans are being developed to share more information about the project with local people.

Throughout May the programme team will be engaging with Healthwatch Cornwall as well as local MPs to discuss the programme and get their feedback and input ahead of a technical go-live. Extensive testing will also continue behind the scenes with system partners and their IT Teams with the aim to have users onboarded following the technical go-live.

The programme board will be meeting in May to discuss the date of the full go-live date.

ENDS

Torbay and South Devon NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 1 2022/23 (April 2022 data)			Meeting date: 25 May 2022
Report appendix	M1 2022/23 IPR focus report M1 2022/23 IPR Dashboard of key metrics		
Report sponsor	Deputy CEO and Chief Finance Officer		
Report author	Head of Performance		
Report provenance	ISU and System governance meetings – review of key performance risks and dashboard Executive Director: 18 May 2022 Integrated Governance Group: 18/19 May 2022 Finance, Performance, and Digital Committee: 23 May 2022		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • Review evidence of overall delivery, against national and local standard and targets • Interrogate areas of risk and plans for mitigation • provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator. Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and evidence presented.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	20
Risk Register	X	**Risk score**	25

External standards affected by this report and associated risks	

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	

This report reflects the following corporate risks:

- failure to achieve key performance standards;
- inability to recruit/retain staff in sufficient number/quality to maintain service provision;
- failure to achieve financial plan.

Report title: Integrated Performance Report (IPR): Month 1 2022/23 (April 2022 data)		**Meeting date:** 25 May 2022
Report sponsor	Deputy Chief Executive & Chief Finance Officer	
Report author	Head of Performance	

The main areas within the Integrated Performance Report that are being brought to the Board's attention are:

1. Quality headlines

CQC: The March 2020 action plan and the December 2021 action plan continue to be overseen and monitored though their respective groups. The Trust remains with 9 Must Do and 8 Should Do actions to complete. These fall into 4 main areas: Staff Training, Staff Appraisals, Environmental Clutter and the Rolling Replacement Programme.
A review of all evidence in relation to the Rolling Replacement Programme and Environmental Clutter, will be undertaken by 30th June to assess if the evidence presented satisfies the requirements to close these 2 actions. If closed, Governance and Oversight will continue through the respective committees.

Incidents: In April 2022 there were;

2 severe incidents reported on STEIS.
- 1 inpatient fall resulting in a fractured hip;
- Ophthalmology delay resulting in lack of vision;

2 deaths reported
- x 1 child death in ED;
- x 1 infant death reported from ED;

Stroke: The percentage of time stroke patients are spending on a stroke ward remains below the 80% target for March, although there has been an improvement in April's performance. The percentage of stroke patients who spend 90% of their hospital stay on a stroke ward has increased from 28.1% to 35.3%. However, only 3.1% of stroke patients were admitted within 4 hours, which remains below target.

VTE assessment: The VTE assessment compliance in March 2022 demonstrated a small reduction in compliance from 94.4% to 91.3%. The VTE group is now well established and this month have a targeted approach to those areas who are below the compliance rate for support and advice.

Infection, Prevention, and Control: There were 30 bed closures reported in April due to D&V. The number of C.Diff cases have remained static within the acute hospital and community from a total of 7 in April.

Maternity: During April 2022, there were 162 births in the month and April and 162 projected for May 2022. The induction of labour rate lowered in April to 28.8% compared to in 37.95% in March.

Midwifery staffing has improved, recruitment continues to fill vacant posts that were secured as part of the Ockenden funding.
We have paused any further roll out of additional teams within the Maternal Continuity of Care model to until fully established.
CNST Year 4 was relaunched on May 6 2022. The self-declaration will be required by Trust boards by January 5 2023.

Nurse Staffing: The Covid-19 nurse safer staffing risk framework remains in place after an increased in staff sickness related to COVID-19, however this position has slightly improved with sickness rates reporting lower numbers. However, wards remain in an overall amber staffing position with mitigations and reassignment to areas according to patient need.

2. Workforce Headlines

The preliminary annual rolling sickness absence rate is 5.57% to the end of April 2022 which is continuing to increase due to the very high figures in 2022 to date; the sickness target rate is 4%. The very high sickness has continued through April with the monthly figure standing at 6.36% which is the 4th month in a row over 6%.

April's Achievement Review rate reduced again to 71.27% from March's 71.87% and is the lowest level in the since May 2020. Continued high absenteeism and system pressures are impacting the ability to perform Achievement Reviews.

The Trust's turnover rate now stands at 13.15% for the year to April 2022 and is within the target range of between 10%-14% and has reduced from March's 13.43%, however, it should be noted that staff retiring and returning are part of these figures.

The April overall rate mandatory training figure increased to 89.55% against a target of 85% and this is a slight increase from the 89.50% figure in March. Information Governance, Manual Handling and Safeguarding Children are all below the target compliance level for Corporate Mandatory training – Slide 7 has been added to highlight the multi-level training compliance.

The Trust Agency reported figure for April was £1.148m, a reduction from the March figure of £1.468m.

3. Performance Headlines

Covid: Throughout April, the Trust experienced a peak of covid hospitalisations, after a rapid increase in March, to a peak of 80 on 28th March, and falling to 10 by 16th May; the number of patients requiring intensive care however remained low reflecting reduced morbidity of covid infection. Staff sickness levels also increased from the surge in covid infections experienced across the community. The workforce escalation plan to divert non-urgent clinical capacity to priority areas with continuation of payment incentives to backfill shifts has mitigated the full impact of these staffing pressures.

Recovery Planning: Despite the recent surge in covid hospitalisations and staff covid-related sickness levels the recovery planning has continued throughout April. The two key elements remained were delivered on schedule for week commencing 24th April being the return of the Day Surgery Unit and increased elective beds to allow the commencement of routine inpatient operating. This follows the successful relocation of

the Medical Receiving Unit (MRU) into the outpatient space and relocation of other outpatient clinic facilities. The biggest impact being on urology who will move their whole outpatient service to the Paignton Hospital site.

Urgent Care: Urgent and emergency services continued to be challenged throughout April however with reduced number of days in highest level of escalation (Opel 4) with OPEL 4 declared on 4 days compared to 18 days in March. High bed occupancy continued to affect delays to ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight. It is noted that in relation to the ICO model of care and admissions avoidance that the number of urgent referrals to intermediate care teams from GP's increased in April to 214 compared with April 2021 of 165. The number of permanent funded placements (per 100k population) in care homes for the over 65's is the highest seen over the last 13 months at 576.

656 people spent 12-hours or more in the Emergency Department this being an improvement from March of 701; ambulance handover delays remain high with 680 patients experiencing a delay of over an hour (March 757) once arriving to the Emergency Department.

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks continued to increase with a small reduction in patient waiting over 104 weeks from 245 in March to 240 at the end of April. The target is to clear all 104 week waits by the end of June.

Capacity within the private sector remains important in supporting delivery of routine elective care along with continued insourcing capacity at weekends for endoscopy and ophthalmology day cases. As part of the 104 week and long wait recovery plan and expansion of insourcing to other surgical specialties is being implemented.
Patient Initiated Follow Up (PIFU) and video/telephone appointments will continue to be developed as a strategy to reduce the waiting time for some patients. In Outpatients, achieving the target of 25% of consultant led outpatient attendance delivered in a non-face to face approach is not being met with 18.8% reported in April.

Cancer recovery plans, specific to delivery of cancer targets, are focusing across the three most challenged areas of dermatology (2-week-wait), urology, and lower GI pathways. These pathways remain high risk and are receiving weekly executive oversight.

Communication with patients with long waits: The Trust is engaged with the Integrated Care System (ICS) system Waiting Well programme. Through this work non-clinical validation of long wait patients "yet to be seen" (longer than 52 weeks) is being supported by the Devon Referrals Support Service (DRSS) by contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well project is also developing information links through various forms of media for patients to give further advice on waiting times and wider support. The Trust has yet to develop its plan to achieve the mandated clinical validation of all patients waiting over 78 weeks on a rolling 3-month basis.

Diagnostic waiting times: MRI, CT**,** Endoscopy, CT, and cardiology MRI remain challenged with a number of patients waiting over 6 weeks for diagnostic tests. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital

facilities will continue to be critical to supporting capacity over the coming months. The national expectation is to plan an increase in diagnostic activity to 120% of 2019/20 levels. This is not being forecast and further work is needed to identify the opportunities to match this expectation.

Patients in hospital: In April, the number of 7-day and 21-day length of stay patients has reduced in April with an average of 171 over 7 days and 45 over 21 days in hospital. This improvement is linked to some further reduction in the number of patients reported as having no criteria to reside and a reduced bed occupancy to allow patients to receive an increased proportion of their care on specialist wards.

In April there was continued reduction in the average number of patients per day recorded as having no criteria to reside from 101 in January to 70 although remaining higher than historic levels indicating there is potential for further improvement. A 50% reduction in no criteria to reside from December 2021 levels has been built into the bed modelling for winter 22/23.

In support of onward packages of care and complex discharges the retention and recruitment of staff remains a significant challenge for independent sector providers who provide nursing residential and domestic care packages of care.

Community and social care: There continues to be a focus on increased productivity across community teams and recruitment to ensure teams can operate at full establishment. The levels of unfilled packages with “no other formal support” remain a concern with an increase to 412 hours in April from 304 in March. The overall risk is being manged to prioritise those patients with no other formal support in place and those leaving acute settings of care

4. Finance headlines

The Trust has achieved a materially balanced revenue position against plan for April (month 01) 22/23, this is based on a planned deficit of £3.4m

Total income for month 01 is £0.5m favourable to plan. Key drivers are as follows:

Non patient services and education and training	£0.2m
Additional CFHD income	£0.5m
Offset by:	
Lower Torbay Pharmaceutical sales	(£0.2m)

Operating expenditure and financing cost in month 01 are £0.5m adverse to plan. Key drivers are as follows:

Agency spend	(£0.5m)
Bank spend	(£0.5m)
Substantive pay	(£0.1m)
CFHD alliance	(£0.5m)
ASC and Placed People savings requirement	(£0.3m)
Offset by	
Business rates adjustment	£0.5m
Depreciation	£0.2m
Drug costs	£0.2m

Miscellaneous expenditure £0.5m

It should be noted that the business rate adjustment is a one-off based on credit notes received from the Local Authority. Therefore, the underlying expenditure position is over £1m adverse to plan in M1.

The cash position at the end of April is £29.69m. It should be noted that the Trust had submitted a Q1 interim PDC revenue cash support request to NHSEI flowing the deadline of 11th May to support the in-year deficit plan.

Spend on capital schemes £3.49m which is slightly ahead of plan at £3.43m for the first month of the financial year.

Month 01 plan for efficiencies was £1.81m, all of which remains un-transacted given there is no NHSE/I reporting for M1. The Trust has an overall efficiency target of £28.5m for 2022/23, which has been phased throughout the financial year.

A number of the pay related efficiency schemes did not commence in Month 1, but remain on schedule to deliver during the first quarter. The Trust's actual financial performance for Month 1 would suggest a potential shortfall of £1.1m against the efficiency target, linked to the position on pay. However, slippage in other areas of spend, along with non-recurrent benefits, have mitigated any shortfall against the efficiency target in-month.

The Trust currently has a planned adjusted deficit of £29.9m for FY 2022/23. The final plan was submitted on 28 April to NHSE/I. The following areas are worth noting:

- The plan is currently not accepted by regulators and further improvement is underway at ICS level with 10 workstreams set-up to drive further opportunities, through consistency in approach and joined up working.
- The planned deficit of £29.9m is after the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives.
- The plan currently includes scaled back ERF allocation from the CCG and matching activities which present significant risks for claw-back if 104% targets and stretch targets are not reached.
- Commissioner contracts are being re-introduced with aligned incentive payment mechanisms for elective activity, which would see the Trust lose income if elective activity fails to achieve the required levels. Details to be confirmed.
- There is no future funding for Hospital Discharge Programme. However, the Trust is in discussion with the ICS and Local Authorities regarding an interim funding and exit strategy.
- Capital plans for 2022-23 and beyond have been developed, there are significant pressures on CDEL allocation.

Integrated Performance Focus Report (IPR) Trust Board

Torbay and South Devon NHS Foundation Trust

May 2022: Reporting period April 2022 (Month 1)

	Section 1: Performance
	Quality and safety
	Workforce
	Community and Social Care
	NHSI operational performance with local performance metric exceptions
	Children and Family Health Devon
	Section 2: Finance
	Finance
	Section 3: Appendices
	Statistical Process Control charts – pilot

Quality and Safety Summary

CQC:

- The March 2020 action plan and the December 2021 action plan continue to be overseen and monitored though their respective groups. The Trust remains with 9 Must Do and 8 Should Do actions to complete. These fall into 4 main areas – Staff Training, Staff Appraisals, Environmental Clutter and the Rolling Replacement Programme.
- A review of all evidence in relation to the Rolling Replacement Programme and Environmental Clutter, will be undertaken by 30th June to assess if the evidence presented satisfies the requirements to close these 2 actions. If closed, Governance and Oversight will continue through the respective committees.

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- The percentage of stroke patients who spend 90% of their hospital stay on a stroke ward has increased from 28.1% to 35.3%
- However, only 3.1% of stroke patients were admitted within 4 hours, which remains below target.

VTE assessment:

- The VTE assessment compliance in March 2022 demonstrated a small reduction in compliance from 94.4% to 91.3% . The VTE group is now well established and this month have a targeted approach to those areas who are below the compliance rate for support and advice.

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- The Covid-19 nurse safer staffing risk framework remains in place after an increased in staff sickness related to COVID-19, however this position has slightly improved with sickness rates reporting lower numbers.
- However wards remain in an overall amber staffing position with mitigations and reassignment to areas according to patient need.

CQC update

The CQCs Inspection Report, published on 2 July 2020 continues to be monitored through CQC and Compliance Assurance Group. This plan was created to address the 28 Requirement Notices (Must Dos) and the 43 Should Do improvements following the CQCs Inspection. Following the April meeting, due to the effects of the omicron variant on staff absence , no actions have been closed, although good progress has been made on 3 of the outstanding actions. Currently, the Trust remains with 9 Must Do and 8 Should Do actions to complete. These fall into 4 main areas – Training, Appraisal, Clutter and rolling replacement programme.

The Estates team are continuing to lead the clutter free environment and a feasibility study is underway to create additional bed and mattress storage on level 4, whilst the physical adjustments to the TAIRU building will conclude in Q1, allowing bulk storage of larger items that need to remain on site for easier access. Governance and Oversight of this action is through the Trust Fire Safety Group and Health and Safety Group. This action will be taken to CQCAG for closure in May 22.

The Trusts recovery programme for training and appraisal has commenced, and the trajectory is to achieve a steady improvement towards full compliance over the next 3 year years. The individual ISU's will still monitor training attendance to ensure full compliance is reached at the earliest opportunity, it is anticipated that some teams will reach compliance within the 3 year trajectory.

The rolling equipment replacement programme has seen replacement commitments being taken into the 22/23 financial year. A review of all evidence will be undertaken by 30 June to assess if this improvement is met in order to seek closure.
Governance and Oversight will be held through the Capital Delivery Group. We ensure that there is a proactive approach to the replacement of our Medical Devices. All Medical Devices are recorded on the asset register with a unique asset number. They are maintained in line with individual Medical device guidance, instructions and regulations, with review dates recorded on the asset register.
The Medical Equipment Priority Group receives allocated funds for replacement via a 3-year replacement plan, to procure the necessary equipment . A peer review of the evidence to support our assurance around this risk will be reviewed at the CQC Governance Group in May and Executive review and sign off in June.
Ongoing audits of patient nutritional risk assessments show a compliance of 83.3% (from the Safety Assessment). Overall, all patient risk assessments show a compliance rate of 85%. This monitoring of assurance is also part of the CQC improvement plan to ensure we can demonstrate good governance, assessment and escalation of risk.

***Table 1: The status of Must Dos and Should Dos per CQC core service*.**

CQC Compliance Actions Status						
CQC Core Service	No. of Actions		Completed		Overdue / Concern	
	Must Do	Should Do	Must Do	Should Do	Must Do	Should Do
Trustwide	1	0	0	n/a	1	n/a
Urgent and Emergency	8	6	6	5	2	1
Medical Care	9	12	5	9	4	3
Surgery	4	5	3	1	1	4
Maternity	4	11	3	11	1	0
Children and Young People (Acute)	1	5	1	5	0	0
Community Inpatients	1	4	1	4	0	0
[illegible]	28	43	19	35	9	8

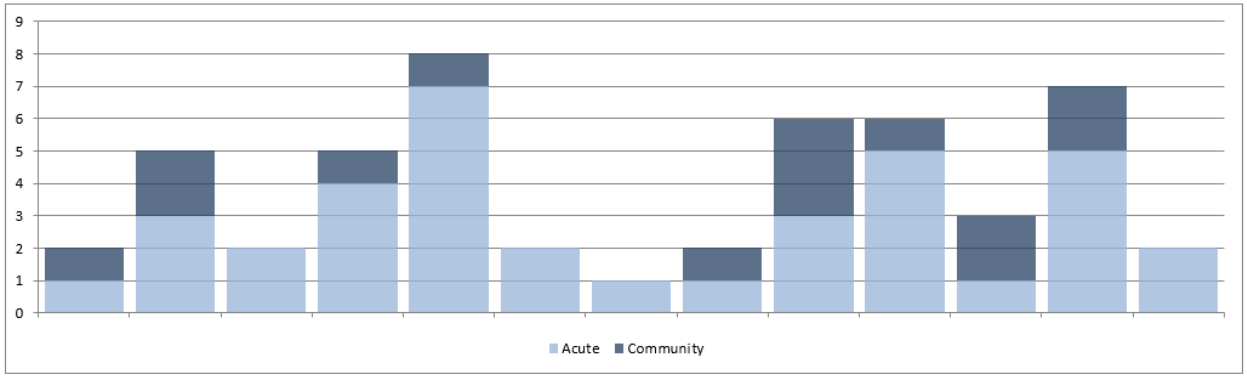
Quality and Safety Indicators

Key							
↑ = Performance improved from previous month ↓ = Performance deteriorated from previous month ↔ = No change							
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Reported Incidents - Severe		↑
Reported Incidents - Death		↑
Medication errors resulting in moderate harm		↔
Medication errors - Total reported incidents		
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)		↓
Never Events		↔
Strategic Executive Information System (STEIS)		↓
QUEST (Quality Effectiveness Safety Trigger Tool		↔
Formal complaints - Number received		↔
VTE - Risk Assessment on Admission		↓
Hospital standardised mortality rate (HSMR)		↔
Safer Staffing - ICO - Daytime		↑
Safer Staffing - ICO – Night time		↑
Infection Control - Bed Closures - (Acute)		↑
Hand Hygiene		↓
Fracture Neck Of Femur - Time to Theatre <36 hours		↓
Stroke patients spending 90% of time on a stroke ward		↑
Mixed sex accommodation breaches		↔
Follow ups 6 weeks past to be seen date		↓

Number of Clostridium Difficile cases

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Acute	1	3	2	4	7	2	1	1	3	5	1	5	2
Community	1	2	0	1	1	0	0	1	3	1	2	2	0



The number of C.Diff cases for April is 7 ;

- 2 of which is hospital onset
- 5 in the community but have had Trust contact in last 28 days

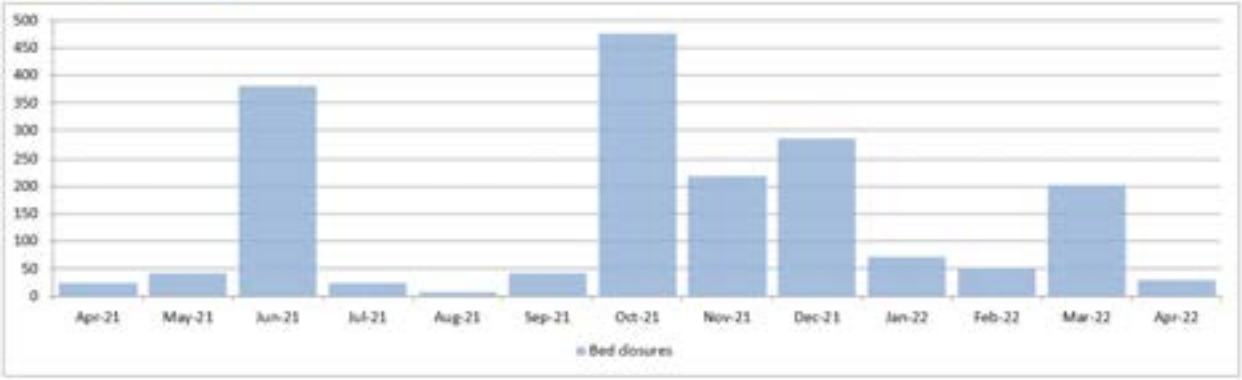
Emerging themes are

- delay in isolation
- sending specimens and giving empirical treatment.

Neither of those incidents, led to acquisition of C.Diff.

Infection control - Bed closures (Acute)

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Bed closures	24	42	381	24	8	42	476	218	285	71	49	203	30



In April a reduced number of bed days lost from D&V is reported. Infection, prevention, and control measures also managed to contain any significant in-hospital transmission of covid-19.

Reported Incidents - Severe and Death

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Severe	0	2	4	2	2	0	1	3	0	4	4	4	2
Death	0	2	1	2	0	0	1	5	0	2	0	3	2

In April there were

- 2 Severe incidents:
  - Inpatient fall #hip (neck of femur)
  - Ophthalmology Delay resulting in loss of vision
- 2 deaths reported:
  - Child death – ED – STEIS
  - Child death ED – pending STEIS

Formal complaints

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Formal complaints	10	9	15	18	17	11	11	10	9	16	11	12	12
Target	60	60	60	60	60	60	60	60	60	60	60	60	60

The Trust received 12 formal complaints in April
Of these 12 complaints:

- x3 with regards delays to diagnosis (various services)
- x2 relate to ineffective communication (various services)

Delays in treatment has been the most common cause of formal complaints for the last 3 months.

Quality and Safety- Exception Reporting

Stroke:

The percentage of stroke patients who spend 90% of their hospital stay on a stroke ward has increased from 28.1% to 35.3%

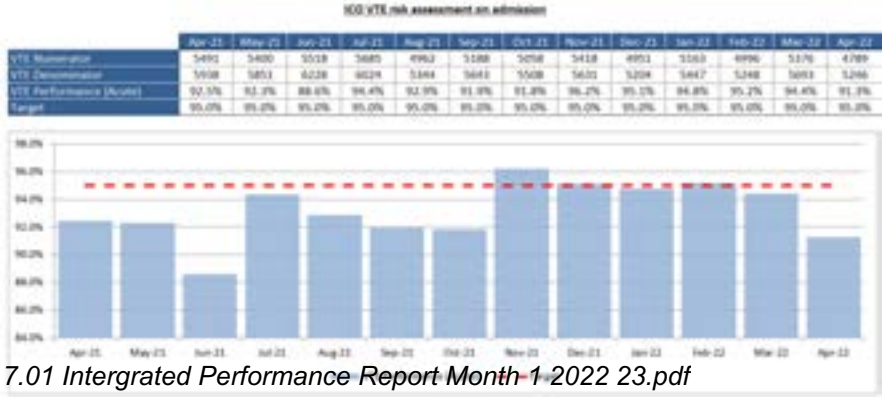
- The stroke ward has been closed for covid reasons during parts of April
- SNP allocated to ED every day, to review and progress treatment and transfer to a stroke bed and oversee their care.
- The stroke team (nurses and therapists) outreach to see stroke patients on other wards.
- The operations team are bidding for equipment to support patients on outlying wards
- The % of patients admitted with 4 hours is 3.6% which is a decrease in performance.

Follow ups:

The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has further increased to 25,516 in March an increase of 1,128.

This data is currently reviewed at the Harm Review group chaired by the Medical Director.

It is expected that backlogs will start to reduce as service improvement changes to reduce follow-up demand are embedded and capacity is fully restored. Where long delays are of concern teams will continue to review and expedite any patients identified as higher risk.



VTE assessment

- The VTE assessment compliance in April 2022 demonstrated a reduction in compliance from 94.4% to 91.3%.
- The VTE Steering Group is established and have reviewed this months data and are targeting one ward and the emergency floor where VTE assessment compliance requires additional focus.
- The group is working on a review of the prescription medication administration chart to move the VTE risk assessment to the front page which will improve visibility at the start of the patients journey.

Quality and Safety- Perinatal Clinical Quality Surveillance May 2022

Following the publication of the Ockenden Report (Dec 2020), national guidance sets out the requirement to strengthen and optimise board oversight for maternity and neonatal safety. Review of maternity and neonatal safety and quality is required monthly by the Trust board

	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	Running Total
% of women booked for continuity of carer	64.2%	64.3%	64.9%	59.7%	65.3%	69.5%	54.0%	65.5%	61.9%	58.9%	50.7%	66.7%	62.1%
Number of Stillbirths	0	0	0	0	2	1	0	1	3	0	0	1	8
% Robson Group 1	0.0%	18.5%	22.9%	3.7%	11.4%	20.0%	24.1%	22.2%	15.4%	10.0%	8.7%	22.2%	14.9%
% Robson Group 2	47.6%	54.7%	48.1%	44.1%	62.5%	37.8%	51.6%	44.9%	57.1%	58.3%	30.3%	55.3%	49.4%
% Robson Group 5	64.7%	68.0%	70.8%	84.6%	82.1%	69.0%	78.6%	88.2%	81.0%	79.2%	90.0%	72.2%	77.4%
% Breastfeeding at Delivery	77.4%	75.3%	74.4%	76.4%	78.1%	71.0%	80.3%	72.2%	80.5%	78.9%	75.2%	78.0%	76.5%

- April has seen a slight improvement in the % of women booked for continuity of carer – 66.7% from March rate of 50.7%.
- There has been an improvement in the number of women choosing to breastfeed at delivery rate during April to 78% from 75% in March.

Performance exceptions and actions

Staff sickness/absence: RED for 12 mths and RED for current mth
The preliminary annual rolling sickness absence rate is 5.57% to the end of April 2022 which is continuing to increase due to the very high figures in 2022 to date; the sickness target rate is 4%. The very high sickness has continued through April with the monthly figure standing at 6.36% which is the 4th month in a row over 6%.

Appraisal rate: **Red**
April's Achievement Review rate reduced again to 71.27% from March's 71.87% and is the lowest level in the since May 2020. Continued high absenteeism and system pressures are impacting the ability to perform Achievement Reviews.

Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 13.15% for the year to April 2022 and is within the target range of between 10%-14% and has reduced from March's 13.43%, however, it should be noted that staff retiring and returning are part of these figures.

Mandatory Training rate: **GREEN**
The April overall rate mandatory training figure increased to 89.55% against a target of 85% and this is a slight increase from the 89.50% figure in March. Information Governance, Manual Handling and Safeguarding Children are all below the target compliance level for Corporate Mandatory training – Slide 7 has been added to highlight the multi-level training compliance.

Agency Expenditure: The Trust Agency reported figure for April was £1.148m, a reduction from the March figure of £1.468m.

Vacancy Rate: The Trust vacancy rate total as at the end of April stood at 352 FTE vacancies including 79 FTE qualified nursing vacancies down from 116 FTE vacancies in March due to the reduction in the Nursing and Midwifery budget. Medical and Dental and Support workers budgets have also been reduced so reducing the reported vacancies, however, the Allied Health Professional budget has increased and the Admin and Clerical Budget has increased significantly so vacancies for these two staff groups are now 72 from 34 for AHP's and 147 from 25 for A&C staff. Detailed vacancy reporting is still difficult in a number of areas at cost centre and occupational code level but is being reviewed on a regular basis and a new process is in place to improve this integrity.

Update of Progress Against Our People Promise and Plan

Reflecting on the KPIs reviewed above, the plans in place to address improvements are built into our strategic People Plan; progress against the 5 pillars is described below. Our People plan dashboard includes the national staff survey findings, which has been reviewed nationally to ensure the findings align to the People promise enabling us to robustly measure how effectively we are delivering Our People Promise – this will be supplemented by the quarterly people pulse survey, which will provides a more regular pulse check.
A report of progress and impact of our year 1 People Promise and Plan is due to be reviewed by the People Committee and Trust Board in June 2022.

1. Growing for Our Future

- Launched the pilot project of targeted local TV adverts seeking to attract from the local community to the main Torbay & South Devon sites. The is running alongside social media adverts as a test phase to inform future resourcing marketing strategy development. This is the first of 3 months of campaigns and each campaign will have a focus to support the resourcing needs of the Trust.
- First face to face and offer on the day event took place 12 May recruiting Healthcare Support Workers, with over 80 attending and over 35 conditional offers to. This was a huge achievement and joint effort between nursing workforce, education (including simulation team), recruitment and resourcing support teams. The event is promoting the increasing support being offered to support career journeys and new education programmes being offered. Members from regional nursing workforce team also attended which was great to share our new approach to recruitment.
- ICS Resourcing activity gaining traction priority to reducing agency spend and increasing temp bank capacity and collaboration across the Devon system.
- Volunteers are returning to the Trust as COVID barriers reduce and the team are a planning for recruitment drive to support increase ward support and way finders as priority roles, using the Volunteers week celebrations to both thank and promote the role of volunteers.
- 2022/23 planning started for the key objectives for the pillar for the coming year, more on this next month

2. Looking After Our People

- Listening sessions continue to take place in hotspot areas across the Trust
- Our Wellbeing Buddy community continues to grow – we currently have 140 active buddies and increasing on a monthly basis
- Our support for teams following critical incidents is being refreshed and as well as the training for new facilitators
- In conjunction with our Charitable funds plans for our wellbeing week "Looking After Me" during 10 – 16 October 22 are well under way
- A series of facilitated reflective sessions for our social care colleagues will be available in June and July. These session will be delivered by Zebra
- Psychology are developing an intervention to support colleagues reflect on trauma through difficult times which we are calling 'Re-set' It is based on GTEP. A polit session has been undertaken

3. New Ways of Working and Delivering Care

- The ICS medical recruitment campaign continues to progress with market research underway to develop the advertising campaign. The six short case study videos are beginning to be filmed and the specialties they will focus on are Respiratory, Oncology, Radiology, Psychiatry, children's mental health and emergency medicine; with each organisation in the ICS taking the lead on one of them. The videos will showcase what its like to live and work in Devon. An identity for the 'We are Devon' medical recruitment website has been developed and agreed by the steering group. The Microsite for medical recruitment in Devon is also being developed.
- The 6 month marketing campaign for the Collaborative bank has now come to an end and proved to be a success; the digital channel impact was as follows: 1000% increase in website visits, 1064% increase in new visitors, 166% increase in followers on social media, 1348% increase in social media users reached. This then led to an impact on the collaborative bank with 197% increase in filled shifts, 178% increase in new enquiries and 133% increase in locums registered. Due to the success a proposal has been taken to the CIS New Ways of Working steering group to run another 6 month marketing campaign.
- A Medical recovery plan group has been set up to deliver and implement a recovery plan for our medical workforce. Confirmation of funding has been given and discussions on the recruitment plan for the medical posts are ongoing.
- The ICS is leading on developing an ICS approach to workforce planning which will align to the ICS Workforce Strategy.
- The national workforce return has been submitted via the ICS. A number of queries have been raised which are being worked through, in conjunction with the Finance Team. The Trust will be required to submit a third version of our workforce plan to the national team on 20th June 2022. The timescales for sign off by the ICS have yet to be determined.

4. Belonging

- As a result of our recent engagement activity our Equality, Diversity and Inclusion (EDI) network chairs have developed a film for national network day sharing what being part of a networks means to them.
- Ensuring that our EDI networks are continuing to influence organisation strategy the Interim Director of Environment presented the Trusts recently published Green Plan seeking support, views and future engagement with the EDI network members as part of delivery of the plan.
- A bespoke BME leadership programme has been commissioned to commence in September, supporting our BME colleagues to develop their leadership and management skills and progress their careers.

5. Creating the Conditions to Enable Transformation

- Building Capability:
- Drumbeat Programme commenced on 26th April with 2 face to face sessions and 1 virtual. The day was full of enthusiasm and positivity. Teams are now working to review their stakeholders and establish regular meetings in order to work on their output booklets. Executive buddy's are being assigned to teams to support them throughout the programme.
- 10-week QI training programme commenced with Pharmacy
- Welcome email sent out to the May cohort of the 4-day QI Practitioner course – starts 17th May.
- 'What is QI' session run for the New Consultants/SAS
- Work with Adel Jones and Deborah Kelly to develop clear roles and responsibilities for the Quality Improvement Plan.
- Meeting to agree joint support (from QI, Nursing, Patient Safety) to roll out the culture survey

Workforce – KPI's (New Ways of Working - Growing for the Future)

Indicator	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Performance
Month Sickness %	4%	4.12%	4.63%	4.75%	5.06%	5.41%	5.87%	5.52%	5.46%	6.03%	6.10%	7.44%	6.36%	
12 Mth Rolling Sickness %	4%	3.98%	4.04%	4.13%	4.24%	4.36%	4.50%	4.56%	4.67%	4.85%	5.03%	5.34%	5.57%	
Achievement Rate %	90%	86.61%	84.73%	81.26%	80.56%	79.69%	77.86%	79.15%	78.57%	76.13%	75.22%	71.87%	71.27%	
Labour Turnover Rate	10-14%	11.03%	11.28%	10.95%	11.73%	11.32%	11.57%	11.51%	11.97%	12.60%	12.86%	13.43%	13.15%	
Overall Training %	85%	90.10%	90.51%	89.53%	89.36%	88.95%	89.02%	88.75%	88.38%	88.62%	89.22%	89.50%	89.55%	
FTE Vacancy	N/A	**196**	**182**	**255**	**117**	**206**	**340**	**378**	**381**	**373**	**392**	**356**	**352**	
Vacancy Factor	<10%	**3.29%**	**3.04%**	**4.22%**	**1.93%**	**3.38%**	**5.46%**	**6.05%**	**6.10%**	**5.95%**	**6.23%**	**5.67%**	**5.62%**	
Monthly Agency Spend	£698K	**£827**	**£1,096**	**£1,284**	**£1,090**	**£1,090**	**£1,231**	**£1,373**	**£1,248**	**£1,025**	**£658**	**£1,468**	**£1,148**	
Nuring Staff Average % Day Fill Rate- Nurses		92%	87%	90%	87%	82%	86%	89%	88%	87%	88%	88%	89%	
Nuring Staff Average % Night Fill Rate- Nurses		90%	89%	93%	88%	75%	81%	84%	81%	78%	79%	79%	80%	
Safer Staffing- Overal CHPPD		8.08	7.71	7.73	7.75	7.55	7.56	7.78	7.93	7.64	7.61	7.56	7.59	

Statistical Process Control (SPC)

SPC is a method of quality control which employs statistical methods to measure, monitor, and control a process. It is a scientific visual method to monitor, control, and improve the process by eliminating special cause variation in a process.

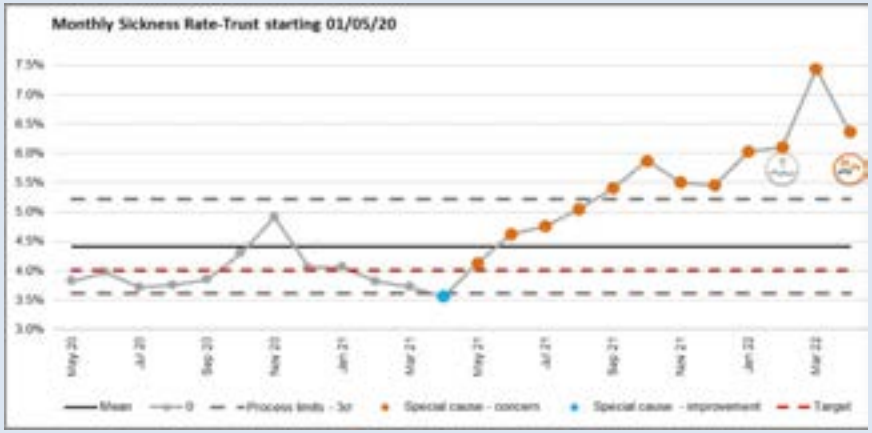
To help you interpret the data a number of rules can be applied.

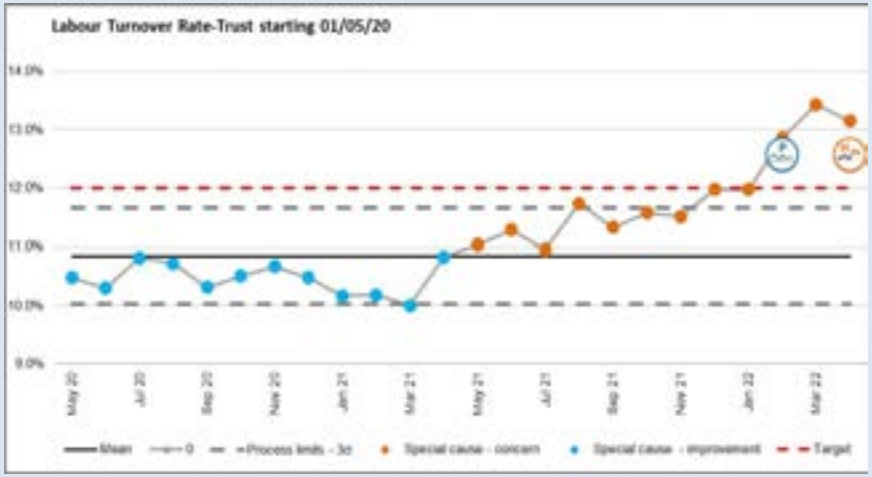
Any single point outside the process limits

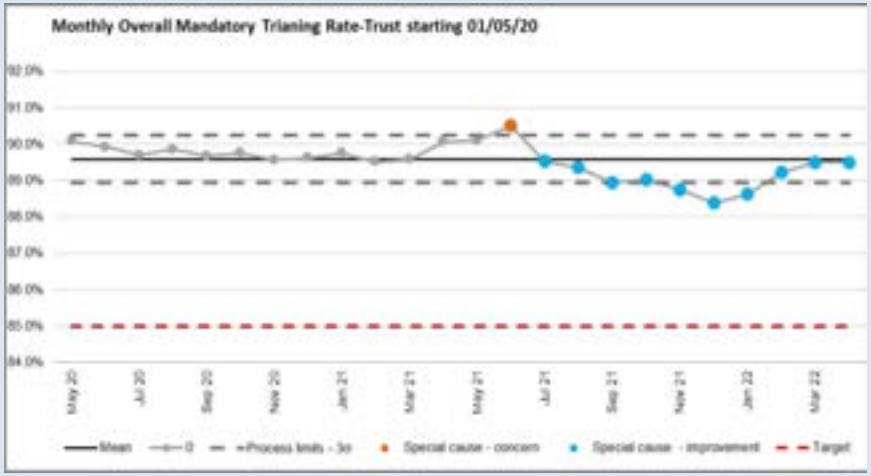
A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).

Any unusual pattern or trend within the process limits.

The number of points within the middle third of the region between the process limits is different from two thirds of the total number of points.







Comments: Sickness continues to be over 6% but a reduction from March/ AR shows a trend below the mean and is continuing to reduce / LTR shows two trends with the most recent the increase in turnover however this has reduced in April and does include retire and return / overall Training compliance continues to improve.

Multiple Level Training Breakdown

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Infection Control L1*	91.00%	90.91%	90.87%	91.62%	91.56%	91.52%	91.18%	90.84%	90.58%	90.77%	91.28%	91.69%
infection Control L2*	82.95%	84.74%	82.48%	82.71%	82.30%	82.28%	82.77%	82.00%	81.64%	82.40%	82.41%	82.60%
Moving & Handling L1*	91.17%	91.27%	90.70%	89.96%	90.61%	90.43%	89.85%	90.11	89.52%	89.69%	90.22%	90.80%
Moving & Handling L2*	63.06%	65.38%	66.45%	68.21%	68.54%	68.37%	67.07%	67.93	68.73%	69.31%	69.50%	68.73%
Safeguarding Adults L1	96.13%	96.09%	95.41%	94.60%	94.22%	94.29%	93.85%	93.55%	94.36%	94.47%	94.71%	94.77%
Safeguarding Adults L2	89.85%	89.95%	88.01%	88.33%	87.99%	87.83%	87.68%	87.07%	87.67%	88.04%	88.56%	88.35%
Safeguarding Adults L3	53.11%	57.42%	56.45%	57.26%	57.22%	59.03%	61.76%	62.90%	58.21%	58.47%	57.58%	58.10%
Safeguarding Adults L4	48.84%	59.09%	54.55%	53.49%	65.85%	63.41%	59.09%	65.91%	62.22%	62.22%	65.12%	65.85%
Safeguarding Adults L5	25.00%	25.00%	25.00%	25.00%	25.00%	75.00%	75.00%	80.00%	80.00%	80.00%	100.00%	100.00%
Safeguarding Adults L6	66.67%	66.67%	66.67%	66.67%	77.78%	77.78%	77.78%	77.78%	77.78%	77.78%	87.50%	87.50%
Mental Capacity Act L1	65.92%	72.74%	75.47%	77.77%	79.69%	81.22%	81.87%	83.13%	84.44%	85.35%	86.51%	87.58%
Mental Capacity Act L2	57.86%	66.58%	69.50%	73.82%	74.20%	76.76%	78.39%	79.06%	79.53%	80.52%	81.74%	81.88%
Mental Capacity Act L3	22.21%	30.72%	35.84%	42.30%	44.77%	48.74%	51.91%	54.86%	56.81%	58.42%	59.98%	61.15%
Mental Capacity Act L4	20.00%	20.00%	20.00%	20.00%	20.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%
Mental Capacity Act L5	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	33.33%	33.33%	100.00%	100.00%
Mental Capacity Act L6	0.00%	0.00%	0.00%	0.00%	85.71%	85.71%	85.71%	85.71%	85.71%	83.33%	83.33%	83.33%
Safeguarding Children L1	93.05%	93.53%	91.82%	91.56%	90.89%	90.98%	89.86%	89.56%	89.09%	89.38%	89.90%	90.21%
Safeguarding Children L2	82.51%	82.69%	80.53%	80.54%	80.29%	80.89%	80.87%	80.52%	80.58%	81.04%	81.38%	81.63%
Safeguarding Children L3	75.20%	72.57%	71.33%	74.04%	70.66%	73.00%	75.96%	73.60%	69.08%	69.12%	73.21%	72.86%
ABLS L1	96.94%	96.99%	96.78%	96.67%	96.61%	96.82%	96.69%	96.87%	98.18%	98.02%	98.17%	98.12%
ABLS L2	68.90%	73.41%	72.87%	74.15%	72.34%	72.87%	72.49%	70.95%	71.57%	70.17%	68.09%	68.80%
AILS L3	60.91%	66.13%	66.67%	65.61%	61.35%	63.49%	64.63%	64.85%	65.49%	61.22%	57.68%	54.58%
AALS L4	57.75%	59.44%	62.59%	34.25%	42.47%	47.22%	46.85%	52.11%	60.36%	60.00%	63.25%	60.49%
PBLS L2	66.25%	69.10%	68.56%	69.15%	69.08%	68.37%	67.96%	66.32%	65.08%	64.38%	63.54%	62.77%
PILS L3	36.23%	38.36%	46.58%	47.83%	52.86%	55.22%	38.10%	39.42%	44.30%	47.20%	43.90%	42.74%
PALS L4	22.73%	25.76%	46.15%	44.12%	41.79%	41.54%	41.79%	37.88%	35.37%	49.23%	50.79%	50.00%
NBLS L2	80.25%	84.47%	81.37%	81.13%	76.13%	67.70%	74.38%	68.75%	71.67%	69.78%	65.41%	61.50%
NBLS L3											61.29%	61.67%

Workforce – KPI's (New Ways of Working - Growing for the Future)

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Total	Strongly Disagree %	Disagree %	Neither Agree or Disagree %	Agree %	Strongly Agree %	Total
I look forward to going to work	17	41	103	90	19	270	6.30%	15.19%	38.15%	33.33%	7.04%	100.00%
I am enthusiastic about my job	9	19	76	110	57	271	3.32%	7.01%	28.04%	40.59%	21.03%	100.00%
Time passes quickly when I am working	6	16	72	99	77	270	2.22%	5.93%	26.67%	36.67%	28.52%	100.00%
There are frequent opportunities for me to show initiative in my role	20	40	45	106	39	250	8.00%	16.00%	18.00%	42.40%	15.60%	100.00%
I am able to make suggestions to improve the work of my team / department	20	34	42	108	46	250	8.00%	13.60%	16.80%	43.20%	18.40%	100.00%
I am able to make improvements happen in my area of work	20	34	42	108	46	250	8.00%	13.60%	16.80%	43.20%	18.40%	100.00%
Care of patients / service users is my organisation's top priority	9	34	63	128	27	261	3.45%	13.03%	24.14%	49.04%	10.34%	100.00%
I would recommend my organisation as a place to work	32	52	67	95	16	262	12.21%	19.85%	25.57%	36.26%	6.11%	100.00%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	18	30	63	123	27	261	6.90%	11.49%	24.14%	47.13%	10.34%	100.00%

The above table shows the results of the latest quarterly Pulse Survey – future Pulse Survey results will start to include trend data to include the results of the previous Pulse Surveys.

Workforce – WTE (New Ways of Working - Growing for the Future)

N&M FTE in-post has increased by 69 FTE since April of last year and M&D has increased by 49 FTE over the same period.
Both the Bank and the Agency FTE Worked figures have reduced significantly from March to April however that is not reflected in the costs for Agency

FTE Staff in Post (NHSI staff Groups from ESR month end data)

NHSI Staff Group	2021/04	2021/05	2021/06	2021/07	2021/08	2021/09	2021/10	2021/11	2021/12	2022/01	2022/02	2022/03	2022/4	Change since April 2021	% Change
Allied Health Professionals	527.08	528.95	524.64	519.16	524.63	538.34	536.58	528.76	527.30	524.64	522.34	520.82	513.97	-13.11	-2.49%
Health Care Scientists	95.17	93.71	93.71	93.71	94.39	92.69	92.70	93.80	92.40	91.36	92.36	91.76	90.16	-5.01	-5.26%
Medical and Dental	527.82	524.87	527.65	556.82	557.43	561.16	561.56	554.68	553.85	552.38	551.50	559.04	576.93	49.11	9.30%
NHS Infrastructure Support	1120.22	1121.66	1126.62	1123.82	1121.33	1122.71	1124.58	1133.69	1134.71	1137.89	1147.56	1149.02	1148.34	28.12	2.51%
Other Scientific, Therapeutic and Technical Staff	342.77	343.99	341.63	348.60	346.41	345.03	346.02	346.89	342.63	342.09	342.02	346.93	351.10	8.33	2.43%
Qualified Ambulance Service Staff	9.52	9.52	9.33	10.33	10.53	10.53	10.53	10.53	10.53	10.53	9.53	10.53	10.45	0.93	9.77%
Registered Nursing, Midwifery and HV staff	1237.33	1239.03	1237.77	1248.15	1254.04	1267.34	1266.85	1267.50	1271.48	1287.67	1293.75	1287.20	1306.43	69.10	5.58%
Support to clinical staff	1880.31	1889.59	1902.13	1898.32	1901.54	1904.65	1899.35	1914.09	1908.06	1899.40	1897.31	1912.84	1907.03	26.72	1.42%
Grand Total	5740.22	5751.33	5763.49	5798.91	5810.30	5842.46	5838.17	5849.93	5840.95	5845.95	5856.38	5878.15	5912.46	172.24	3.00%

Pay Report Summary for the last 12 months

	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
Cost	£	£	£	£	£	£	£	£	£	£	£	£
Substantive	£21,422,432	£21,269,748	£21,100,577	£21,485,466	£25,412,838	£22,212,036	£22,229,296	£22,000,915	£22,354,848	£22,715,706	£35,278,455	£23,784,603
Bank	£1,040,420	£991,252	£1,098,843	£997,363	£1,177,818	£1,105,903	£1,155,652	£1,170,666	£1,090,632	£1,217,561	£1,436,187	£1,342,004
Agency	£827,832	£1,095,792	£1,284,092	£1,090,236	£1,191,740	£1,231,573	£1,373,403	£1,247,147	£1,025,186	£658,009	£1,467,363	£1,146,711
Total Cost £	£23,290,684	£23,356,792	£23,483,512	£23,573,065	£27,782,396	£24,549,512	£24,758,351	£24,418,728	£24,470,667	£24,591,276	£38,182,005	£26,273,318
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	5,757.26	5,762.25	5,750.55	5,848.93	5,887.22	5,868.32	5,852.42	5,861.51	5,875.21	5,922.11	5,961.13	5,972.99
Bank	269.23	317.11	336.05	247.74	313.21	272.84	350.26	343.70	215.37	333.80	348.91	292.62
Agency	116.45	161.66	151.10	143.60	174.75	174.59	182.45	172.07	147.00	140.10	212.24	162.93
Total Worked WTE	6,142.94	6,240.99	6,237.70	6,240.27	6,375.18	6,315.75	6,385.13	6,377.28	6,237.57	6,396.02	6,522.28	6,428.54

Workforce – Vacancies (12 months rolling) - (New Ways of Working - Growing for the Future)

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Medical And Dental	541.66	542.30	543.04	545.08	546.21	546.61	551.92	552.62	554.97	555.12	555.27	555.27	537.50
Nursing And Midwifery Registered	1,325.10	1,321.76	1,323.84	1,331.03	1,332.16	1,342.46	1,408.99	1,411.72	1,412.10	1,414.24	1,413.96	1,412.88	1,384.03
Support To Clinical Staff	1,917.95	1,917.53	1,921.00	1,947.00	1,957.12	1,971.99	2,016.16	2,027.12	2,027.91	2,035.32	2,037.44	2,037.57	1,950.33
Add Prof Scientific and Technic	431.92	431.19	434.19	435.19	436.19	436.19	445.02	445.02	446.02	446.02	460.53	460.53	441.11
Allied Health Professionals	493.43	495.28	498.80	504.60	512.00	512.00	508.88	508.41	509.58	509.78	509.78	509.78	540.16
Healthcare Scientists	99.60	99.60	100.02	102.19	103.19	103.19	104.19	103.91	104.90	104.90	104.90	104.90	105.64
Qualified Ambulance Service Staff	5.80	5.80	5.80	5.80	5.80	5.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80
Administrative And Estates	1,157.25	1,157.46	1,162.98	1,164.98	1,167.06	1,169.22	1,186.88	1,186.88	1,192.92	1,193.92	1,196.97	1,188.27	1,307.23
Total Staff Budgeted WTE	5,972.71	5,970.92	5,989.69	6,035.89	6,059.75	6,087.48	6,228.84	6,242.48	6,255.19	6,266.10	6,285.64	6,276.00	6,272.80

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Medical And Dental	524.76	522.61	524.21	521.61	616.14	545.85	551.08	543.11	534.76	538.94	542.01	548.01	551.66
Nursing And Midwifery Registered	1,246.22	1,246.20	1,246.99	1,248.93	1,258.71	1,266.77	1,272.47	1,273.93	1,280.61	1,288.11	1,298.77	1,296.64	1,305.03
Support To Clinical Staff	1,898.96	1,878.21	1,909.51	1,887.68	1,928.06	1,934.83	1,916.68	1,911.69	1,909.88	1,913.99	1,898.81	1,917.73	1,919.01
Add Prof Scientific and Technic	406.84	406.93	410.04	411.09	424.86	413.28	418.97	403.66	413.99	414.68	416.53	414.95	414.83
Allied Health Professionals	479.38	480.14	479.20	470.70	473.80	482.36	488.14	485.86	484.17	485.77	476.60	475.29	467.67
Healthcare Scientists	99.17	100.17	98.72	98.72	99.40	98.16	97.69	99.30	97.80	96.36	96.36	96.77	94.77
Qualified Ambulance Service Staff	10.72	5.60	6.52	7.52	8.41	7.61	10.61	7.61	7.61	8.61	8.61	7.61	7.61
Administrative And Estates	1,128.59	1,134.90	1,132.52	1,134.71	1,133.17	1,132.60	1,132.84	1,139.50	1,144.93	1,146.70	1,156.45	1,163.14	1,159.95
Total Staff Worked WTE	5,794.64	5,774.76	5,807.70	5,780.96	5,942.54	5,881.46	5,888.47	5,864.67	5,873.75	5,893.15	5,894.15	5,920.15	5,920.52

Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Medical And Dental	16.90	19.69	18.83	23.47	-69.93	0.76	0.84	9.51	20.21	16.18	13.26	7.26	-14.16
Nursing And Midwifery Registered	78.88	75.56	76.85	82.10	73.46	75.69	136.52	137.78	131.48	126.13	115.19	116.24	79.00
Support To Clinical Staff	18.99	39.32	11.49	59.32	29.07	37.17	99.48	115.43	118.03	121.33	138.62	119.83	31.32
Add Prof Scientific and Technic	25.08	24.26	24.15	24.10	11.33	22.91	26.05	41.36	32.03	31.34	44.00	45.58	26.28
Allied Health Professionals	14.05	15.14	19.61	33.90	38.21	29.64	20.74	22.55	25.41	24.01	33.18	34.49	72.49
Healthcare Scientists	0.43	-0.57	1.30	3.47	3.79	5.03	6.50	4.61	7.10	8.54	8.54	8.13	10.87
Qualified Ambulance Service Staff	-4.92	0.20	-0.72	-1.72	-2.61	-1.81	-3.81	-0.81	-0.81	-1.81	-1.81	-0.81	-0.81
Administrative And Estates	28.66	22.56	30.46	30.27	33.90	36.63	54.04	47.38	47.99	47.22	40.52	25.13	147.28
Total Staff Worked WTE	178.07	196.16	181.98	254.93	117.21	206.01	340.37	377.81	381.45	372.95	391.50	355.85	352.28

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso – The budget setting process for the year 2022-23 has seen reductions in N&M, M&D, Support to Clinical and the Scientific & Technical staff groups but there has been an increase in the AHP budget and a significant increase in the Admin and Clerical budget. These budget changes have has a significant impact to overall vacancies with the M&D staff group over budget and N&M vacancies reducing from 116FTE down to 79 FTE but the A&C vacancies has significantly increased from 25 FTE to 147 FTE.

Workforce – Agency (New Ways of Working - Growing for the Future)

The table below shows the agency expenditure by staff Group monthly for the Financial Year 2021-22 and the first month of the 2022-23 Financial Year.

The February and March figures show a significant variance and will be in part Finance adjustments alongside the significant staff absenteeism through March. The April figure of £1.1m is a reduction from the very high March figure of £1.4m.

Torbay and South Devon NHS Foundation Trust	2021-22 Financial Year													2022-23
Total Agency Spend	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**2021-22 Total**	**Apr-22**
Registered Nurses	356	348	468	584	520	599	557	676	570	432	408	818	6336	546
Scientific, Therapeutic and Technical	43	99	142	122	110	112	162	140	144	147	130	67	1418	93
of which Allied Health Professionals	31	45	63	58	65	47	65	70	80	88	86	23	721	52
of which Other Scientific, Therapeutic and Technical Staff	12	54	79	64	45	65	96	70	64	59	44	44	696	41
Support to clinical staff (HCA)	-1	-10	-3	7	-8	2	15	19	13	35	31	24	124	32
Total Non-Medical - Clinical Staff Agency	398	437	607	713	622	713	734	835	727	614	569	909	7878	671
Medical and Dental Agency	243	262	353	455	328	317	322	390	378	265	-63	370	3621	321
Consultants	213	203	281	344	178	171	212	278	245	167	11	250	2554	230
Trainee Grades	30	59	72	111	150	146	110	112	133	98	-74	120	1067	91
Non Medical - Non-Clinical Staff Agency	114	128	136	116	140	162	174	148	143	146	152	189	1748	156
Total Pay Bill Agency and Contract	755	827	1096	1284	1090	1192	1231	1373	1248	1025	658	1468	13248	1148

Safer Staffing – Planned versus Actual (New Ways of Working - Growing for the Future)

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff			Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Ainslie	1725	1405	0	0	1725	1842	1380	1024	0	0	1035	1093	738	81.4%	0.0%	106.8%	74.2%	0.0%	105.6%
Allerton	2814	1753	0	0	1035	1667	1380	1023	0	0	1035	1050	738	62.3%	0.0%	161.1%	74.1%	0.0%	101.4%
Cheetham Hill	1380	1660	345	0	2070	1994	1035	806	345	0	1380	2084	809	120.3%	0.0%	96.3%	77.9%	0.0%	151.0%
Coronary Care	1380	1271	0	0	0	0	1035	1035	0	0	0	0	368	92.1%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1622	1354	0	0	863	1022	1035	1012	0	0	690	776	646	83.5%	0.0%	118.5%	97.8%	0.0%	112.4%
Dunlop	1380	1228	0	0	1208	1310	1035	886	0	0	1035	1138	708	89.0%	0.0%	108.5%	85.6%	0.0%	110.0%
Forrest	1725	1630	690	0	1380	1309	1725	1196	690	0	1380	1178	727	94.5%	0.0%	94.9%	69.3%	0.0%	85.3%
EAU4	1725	972	0	0	1380	1464	1725	1150	0	0	1380	1158	719	56.3%	0.0%	106.1%	66.7%	0.0%	83.9%
Ella Rowcroft	1035	849	0	0	1380	1019	989	759	0	0	690	661	365	82.0%	0.0%	73.8%	76.7%	0.0%	95.8%
Warrington	1035	1119	0	0	690	862	690	690	0	0	690	825	500	108.1%	0.0%	124.9%	100.0%	0.0%	119.5%
George Earle	1380	1605	345	0	2070	1681	1035	1024	0	0	1380	1512	806	116.3%	0.0%	81.2%	98.9%	0.0%	109.6%
ICU	3450	2522	0	0	0	288	3105	2185	0	0	0	0	176	73.1%	0.0%	0.0%	70.4%	0.0%	0.0%
Joan Williams	690	687	0	0	690	655	690	634	0	0	690	708	295	99.5%	0.0%	94.9%	91.8%	0.0%	102.6%
Louisa Cary	2070	1515	0	0	690	797	2070	1403	0	0	690	714	415	73.2%	0.0%	115.5%	67.8%	0.0%	103.5%
Escalation (McCullum)	690	765	0	0	690	944	690	540	0	0	690	955	469	110.8%	0.0%	136.7%	78.3%	0.0%	138.3%
Midgley	1725	1761	0	0	1725	1316	1725	1087	0	0	1380	1369	848	102.1%	0.0%	76.3%	63.0%	0.0%	99.2%
SCBU	1035	964	0	0	345	187	1035	772	0	0	345	253	181	93.1%	0.0%	54.1%	74.5%	0.0%	73.3%
Simpson	1380	1533	345	0	2047	1969	1035	940	0	0	1380	1413	772	111.1%	0.0%	96.2%	90.8%	0.0%	102.4%
Turner	1035	1016	0	0	1725	1656	690	656	0	0	1380	1063	464	98.1%	0.0%	96.0%	95.0%	0.0%	77.0%
Total (Acute)	*29276*	*25602*	*1725*	*0*	*21712*	*21979*	*24104*	*18819*	*1035*	*0*	*17250*	*17946*	*10744*	87.5%	0.0%	101.2%	78.1%	0.0%	104.0%
Brixham	840	890.75	420	0	1260	1289	990	706	0	0	660	817.25	472	106.0%	0.0%	102.3%	71.3%	0.0%	123.8%
Dawlish	840	1146	0	0	1050	750.5	720	702.5	0	0	660	627.5	468	136.4%	0.0%	71.5%	97.6%	0.0%	95.1%
John Macpherson	1035	890	0	0	541	686	690	794	0	0	690	668	278	86.0%	0.0%	126.9%	115.0%	0.0%	96.7%
NA - Teign Ward	1890	1520.25	0	0	1890	1572.5	990	835.5	0	0	990	1101.75	881	80.4%	0.0%	83.2%	84.4%	0.0%	111.3%
NA - Templar Ward	1680	1546	0	0	2128	1958.25	990	754	0	0	1080	1244	885	92.0%	0.0%	92.0%	76.2%	0.0%	115.2%
Totnes	840	801.5	0	0	1260	1211.5	720	662	0	0	660	663	526	95.4%	0.0%	96.2%	91.9%	0.0%	100.5%
Organisational Summary	36401	32397	2145	0	29841	29447	29204	23272	1035	0	21990	23067	14254	89.0%	0.0%	98.7%	79.7%	0.0%	104.9%

- The Registered Nurse (RN) average fill rate for day has increased in April 22 to 89.0%% from 88.83% in Mar 22 and the night fill rate has increased to 79.7% in April 22 from 78.8% in Mar 22. This slight improvement in fill rate is multifactorial and includes increased temporary staffing fill and a slight reduction in Registered Nurse Vacancies (11WTE increase).
- The Health Care Support Worker (HCSW) average fill rate for day was 98.7% and night was recorded as 104.9% which is an decrease for both days and nights but more in line with the safer staffing establishment. The slightly high fill rate at night was to provide supportive observation.

Areas to note in April 22	Driver	Mitigations
Allerton	Low RN fill rate during the day	Additional HCSW rostered to support. Patient acuity monitored to ensure safe delivery of care continues.
EAU 4	Low RN fill rate during the day and overnight	Additional HCSW rostered to support while active recruitment continues.

Safer Staffing – Care hours per patient day (CHPPD) and planned versus actual (New Ways of Working - Growing for the Future)

CHPPD Monthly Summary

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	7.52	3.98	0.00	3.54	7.30	3.30	0.00	4.00	19	26	0	4	63.3%	86.7%	0.0%	13.3%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.40	3.80	0.00	3.70	17	29	0	1	56.7%	96.7%	0.0%	3.3%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	8.10	3.00	0.00	5.00	4	9	30	2	26.7%	20.0%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.30	6.30	0.00	0.00	5	5	0	0	16.7%	16.7%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.53	3.54	0.00	1.99	6.40	3.70	0.00	2.80	4	10	0	1	13.3%	33.3%	0.0%	3.3%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.40	3.00	0.00	3.50	15	27	0	5	50.0%	90.0%	0.0%	16.7%	7.74	4.74	0	2.91
Forrest	10.12	4.60	1.84	3.68	7.30	3.90	0.00	3.40	29	24	30	20	96.7%	80.0%	100.0%	66.7%	7.74	4.74	0	2.91
EAU4	8.28	4.60	0.00	3.68	6.60	3.00	0.00	3.60	27	30	0	15	90.0%	100.0%	0.0%	50.0%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	9.00	4.40	0.00	4.60	0	2	0	2	0.0%	6.7%	0.0%	6.7%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.00	3.60	0.00	3.40	1	2	0	1	3.3%	6.7%	0.0%	3.3%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	7.20	3.30	0.00	4.00	15	3	30	17	50.0%	10.0%	100.0%	56.7%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	28.40	26.70	0.00	1.60	4	6	0	0	13.3%	20.0%	0.0%	0.0%	7.74	4.74	0	2.91
Joan Williams	8.36	4.18	0.00	4.18	9.10	4.50	0.00	4.60	10	7	0	10	33.3%	23.3%	0.0%	33.3%	7.74	4.74	0	2.91
Louisa Cary	7.36	5.52	0.00	1.84	10.70	7.00	0.00	3.60	1	1	0	0	0.0%	3.3%	0.0%	0.0%	7.74	4.74	0	2.91
Escalation (McCullum)	6.57	3.29	0.00	3.29	6.80	2.80	0.00	4.00	14	25	0	3	46.7%	83.3%	0.0%	10.0%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	6.50	3.40	0.00	3.20	29	29	0	25	96.7%	96.7%	0.0%	83.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	12.00	9.60	0.00	2.40	3	3	0	14	10.0%	10.0%	0.0%	46.7%	7.74	4.74	0	2.91
Simpson	7.19	2.88	0.41	3.90	7.60	3.20	0.00	4.40	8	6	30	0	26.7%	20.0%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	10.73	3.83	0.00	6.90	9.50	3.60	0.00	5.90	23	18	0	24	76.7%	60.0%	0.0%	80.0%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	7.80	3.40	0.00	4.50	7	6	30	1	23.3%	20.0%	100.0%	3.3%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	6.90	3.90	0.00	2.90	13	3	0	24	43.3%	10.0%	0.0%	80.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	10.90	6.10	0.00	4.90	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	5.70	2.70	0.00	3.00	29	30	0	20	96.7%	100.0%	0.0%	66.7%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.20	2.60	0.00	3.60	19	25	0	10	63.3%	83.3%	0.0%	33.3%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.30	2.80	0.00	3.60	18	18	0	18	60.0%	60.0%	0.0%	60.0%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.63	4.15	0.20	3.28	7.59	3.91	0.00	3.68

- The RN actual CHPPD for TSD has increased to 3.91 in April 22 from 3.84 in Mar 22, which although a slight improvement remains below the Carter recommendation of 4.7.
- The HCA actual CHPPD is at 3.68 which is above the Carter recommendation of 2.91.
- During April the operational position improved although 22 days were declared at OPEL 3 and 4 days at OPEL 4. The total planned CHPPD was recorded as 7.63 and the actual was reported as 7.59.

Areas of concern	Driver	Mitigations
Forrest & EAU 4	High number of RN vacancies	Recruitment strategy underway to substantiate escalation areas. Twice daily staffing meetings and clear escalation routes.

Community and Social Care Indicators

Key							
↑ = Performance improved from previous month ↓ = Performance deteriorated from previous month ↔ = No change							
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Carers Assessments Completed year to date		↔
Children with a Child Protection Plan (one month in arrears)		
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		↔
Community Hospital - Admissions (non-stroke)		
Proportion of clients receiving self-directed support (ASCOF)		↔
Proportion of carers receiving self-directed support (ASCOF)		↔
Percentage of Adults with learning disabilities in employment (ASCOF)		↑
Percentage of adults with learning disabilities in settled accommodation (ASCOF)		↔
Permanent admissions (18-64) to care homes per 100k population (ASCOF)		↓
Permanent admissions (65+) to care homes per 100k population (ASCOF)		↓
Proportion of clients receiving direct payments (ASCOF)		↓
% reablement episodes not followed by long term SC support		↓

Operational update:

Front End Service (FES) and Complex Care Service (CCS) have seen a reduction in waiting list numbers. Careful monitoring is in place due to pressure on workforce due to covid related sickness and outstanding vacancies. Both FES and CCS are continuing to improve their case closure rates. Interim structure is embedded well and monitoring of staff performance is part of a drive for continuous improvement in supporting staff to deliver high quality Adult Social Care.

Care Accounts is a key project between TSDFT and Local Authority and planning is underway. During the current Discovery Phase of the planning, the newly formed joint TSDFT and Torbay Council project team is working together alongside Local Government Association and NHS Transformation as part of the Pathfinder Programme. The Pathfinder Programme will provide further support in terms of technical and operational readiness from central government and will take lessons earned from Trailblazer Local Authorities.

Adult Social Care Improvement Plan (ASCiP) has implemented its plans for the 2022/23 Cost Improvement Plan Savings. As a result of adopting a strength-based approach to reassessments in accordance with the Care Act 2014 outcome focused approach to social care, the first quarter on 2022/23 is promising. The second stage of transformation for 2022/23 has been prioritised alongside central government requirements for social care charging reform (Care Accounts) which will bring forward the need to improve information, advice and guidance for citizens of Torbay.

Social Care and Public Health performance metrics - Torbay

The Social Care and Public Health metrics below relate to the Torbay LA commissioned services. The Deputy Director of Social Care reviews all Adult Social Care (ASC) monthly metrics and escalates areas of concern at the monthly Integrated Governance Group (IGG). Governance will be assured by the ASC Performance Committee reports feeding into both the ICO's IGG and Torbay Council's ASC Improvement Board.

	ISU	Target	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide	94%		72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide	7%		7.5%	7.4%	7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%
% Adults with learning disabilities in settled accommodation	Trustwide	80%		93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		17.5	20.2	23.1	17.7	19.0	17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		499.8	510.8	487.3	498.1	511.5	449.6	422.7	411.9	376.9	487.5	476.5	570.8	576.2	576.2
Proportion of clients receiving direct payments	Trustwide	25%		20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%					85.9%	87.1%	87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	84.5%

Measure	Target 2022/2023	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date 2022/23
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		92.5%	86.6%	80.4%	74.4%	81.0%	72.9%	83.8%	82.1%	80.2%	78.8%	84.4%	70.3%	73.6%	73.6%
Children with a child protection plan *			234	213	201	171	165	147	147	-	-	-	-	-	-	..
Opiate users - % successful completions of treatment (Quarterly) **	Var				4.3%			5.2%								..

Public Health Torbay : The COVID-19 response for patient facing services have had to manage with reduced capacity with only essential services maintained. Teams are making assessments of their recovery plans risks and actions that will be needed to see a return to the capacity needed to meet ongoing demand.
Quarterly data is shown in arrears for smoking, opiate users, and children with a protection plan.

As a provider of Health and Social Care, Trust teams either commission directly from the independent sector or work in partnership with Devon County Council to secure the necessary capacity in the community. This includes domiciliary care which is essential to provide people as much independence as possible avoiding hospital bed-based care where this is not adding clinical value. The ability to measure unfilled packages and correlate these with patients awaiting support to step down from short term placement or from community or acute hospital bed provision enables action to be taken to close capacity gaps.

Chart 1- Hours of care given

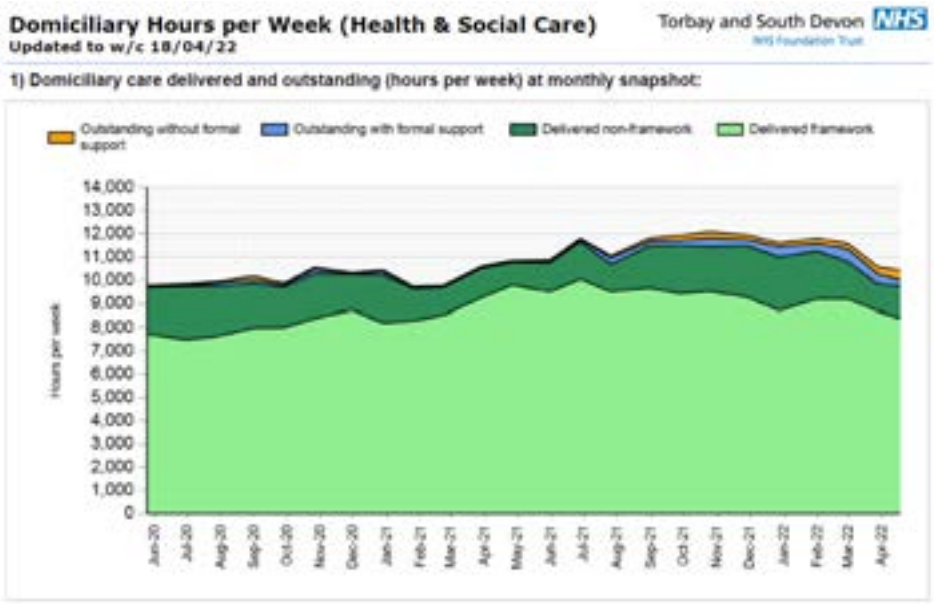


Chart 2 -Unmet packages of care

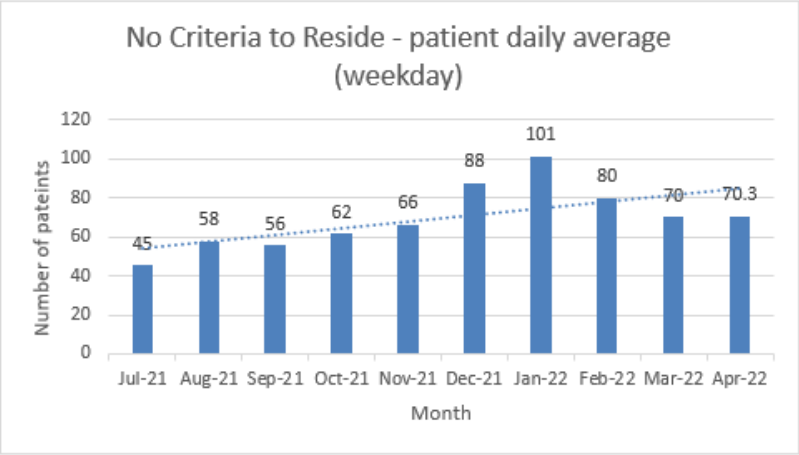
Chart 1 – 'Hours of care given' shows the latest data available for total commissioned domiciliary hours by week for Torbay. The amount of care provided is seen along with the unmet/outstanding demand. The outstanding hours without formal support are of highest concern. In April there is an increase in the number of hours outstanding for clients with no formal support. Weekly snapshot in March (304 hours) outstanding increased to 412 hours without formal support in April.

Chart 2- "Unmet packages of care" shows the number of unmet packages of care for South Devon (orange) and Torbay (Green) and where provided by diverting other NHS community provision (Blue). Current levels remain significantly higher than those reported in Q1 2021/22.

Across the sector there are significant workforce recruitment and retention challenges so increasing capacity is very difficult at this time. However, increasing the capacity in the domestic care sector will be critical if we are to support the flow of patients from an acute setting where a new or changed package of care is needed.

Criteria To Reside

The Trust records a patient's Criteria to Reside daily. The Graph below is for whole ICO bed base acute and community hospital beds:



The average number of patients with no criteria to reside decreased from the peak seen in January. However, the number of delayed discharges continues to be above historical levels. The Trust is in the process of describing actions against a 'complex discharge pathway improvement plan' to support operational bed capacity and flow.

The graphs opposite show the split of patient per day by discharge pathway (taken as a snapshot) with No Criteria to Reside reported. The graphs reflect a reduction in the number of patients waiting for a short-term placement, however, delays for long-term placement and home with support continue to be significantly above historical levels. All patients requiring a complex discharge are managed and reviewed through the Discharge Hub and are reviewed on a daily basis.

Pathway 0 = Simple discharge - no additional support
Pathway 1 = Home / usual residence with support
Pathway 2 = Short term placement - rehab/reablement in a temporary bedded setting
Pathway 3 = Long term placement - complex support package / long term placement

Operational Performance Summary – Page 1

Operational performance summary: Chief Operating Officer

Covid: Throughout April, the Trust experienced a peak of covid hospitalisations, after a rapid increase in March, to a peak of 80 on 28th March, and falling to 10 by 16th May; the number of patients requiring intensive care however remained low reflecting reduced morbidity of covid infection. Staff sickness levels also increased from the surge in covid infections experienced across the community. The workforce escalation plan to divert non-urgent clinical capacity to priority areas with continuation of payment incentives to backfill shifts has mitigated the full impact of these staffing pressures.

Recovery Planning: Despite the recent surge in covid hospitalisations and staff covid-related sickness levels the recovery planning has continued throughout April. The two key elements remained were delivered on schedule for week commencing 24th April being the return of the Day Surgery Unit and increased elective beds to allow the commencement of routine inpatient operating. This follows the successful relocation of the Medical Receiving Unit (MRU) into the outpatient space and relocation of other outpatient clinic facilities. The biggest impact being on urology who will move their whole outpatient service to the Paignton Hospital site.

Urgent Care: Urgent and emergency services continued to be challenged throughout April however with reduced number of days in highest level of escalation (Opel 4) with OPEL 4 declared on 4 days compared to 18 days in March. High bed occupancy continued to affect delays to ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight. It is noted that in relation to the ICO model of care and admissions avoidance that the number of urgent referrals to intermediate care teams from GP's increased in April to 214 compared with April 2021 of 165. The number of permanent funded placements (per 100k population) in care homes for the over 65's is the highest seen over the last 13 months at 576.
656 people spent 12-hours or more in the Emergency Department this being an improvement from March of 701; ambulance handover delays remain high with 680 patients experiencing a delay of over an hour (March 757) once arriving to the Emergency Department.

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks continued to increase with a small reduction in patient waiting over 104 weeks from 245 in March to 240 at the end of April. The target is to clear all 104 week waits by the end of June.
Capacity within the private sector remains important in supporting delivery of routine elective care along with continued insourcing capacity at weekends for endoscopy and ophthalmology day cases. As part of the 104 week and long wait recovery plan and expansion of insourcing to other surgical specialties is being implemented.
Patient Initiated Follow Up (PIFU) and video/telephone appointments will continue to be developed as a strategy to reduce the waiting time for some patients. In Outpatients, achieving the target of 25% of consultant led outpatient attendance delivered in a non face to face approach is not being met with 18.8% reported in April.
Cancer recovery plans, specific to delivery of cancer targets, are focusing across the three most challenged areas of dermatology (2-week-wait), urology, and lower GI pathways. These pathways remain high risk and are receiving weekly executive oversight.

Communication with patients with long waits: The Trust is engaged with the Integrated Care System (ICS) system Waiting Well programme. Through this work non-clinical validation of long wait patients "yet to be seen" (longer than 52 weeks) is being supported by the Devon Referrals Support Service (DRSS) by contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well project is also developing information links through various forms of media for patients to give further advice on waiting times and wider support. The Trust has yet to develop its plan to achieve the mandated clinical validation of all patients waiting over 78 weeks on a rolling 3 month basis.

Diagnostic waiting times: MRI, CT**,** Endoscopy, CT, and cardiology MRI remain challenged with a number of patients waiting over 6 weeks for diagnostic tests. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities will continue to be critical to supporting capacity over the coming months. The national expectation is to plan an increase in diagnostic activity to 120% of 2019/20 levels. This is not being forecast and further work is needed to identify the opportunities to match this expectation.

Patients in hospital: In April, the number of 7-day and 21-day length of stay patients has reduced in April with an average of 171 over 7 days and 45 over 21 days in hospital. This improvement is linked to some further reduction in the number of patients reported as having no criteria to reside and a reduced bed occupancy to allow patients to receive an increased proportion of their care on specialist wards.

In April there was continued reduction in the average number of patients per day recorded as having no criteria to reside from 101 in January to 70 although remaining higher than historic levels indicating there is potential for further improvement. A 50% reduction in no criteria to reside from December 2021 levels has been built into the bed modelling for winter 22/23.

In support of onward packages of care and complex discharges the retention and recruitment of staff remains a significant challenge for independent sector providers who provide nursing residential and domestic care packages of care.

Community and social care: There continues to be a focus on increased productivity across community teams and recruitment to ensure teams can operate at full establishment. The levels of unfilled packages with "no other formal support" remain a concern with an increase to 412 hours in April from 304 in March. The overall risk is being manged to prioritise those patients with no other formal support in place and those leaving acute settings of care.

Operational Performance Indicators

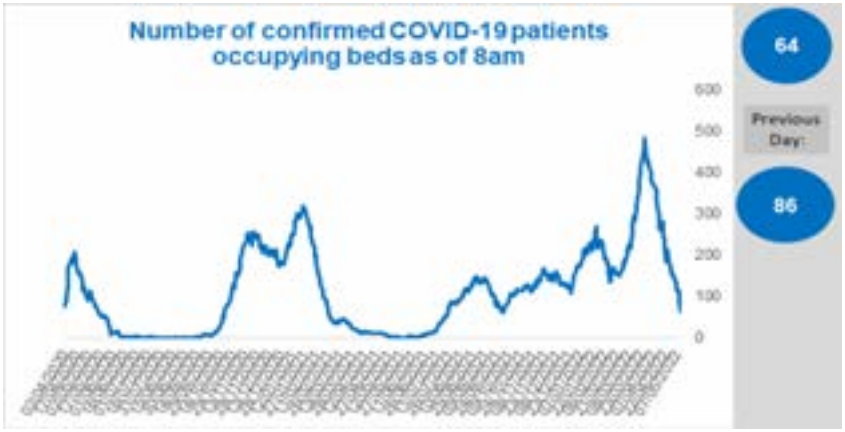
Key									
⬆ = Performance improved from previous month ⬇ = performance deteriorated from previous month ⟷ = no change									
	Not achieved		Under-achieved		Achieved		No target set		Data not available		NHSI Indicator

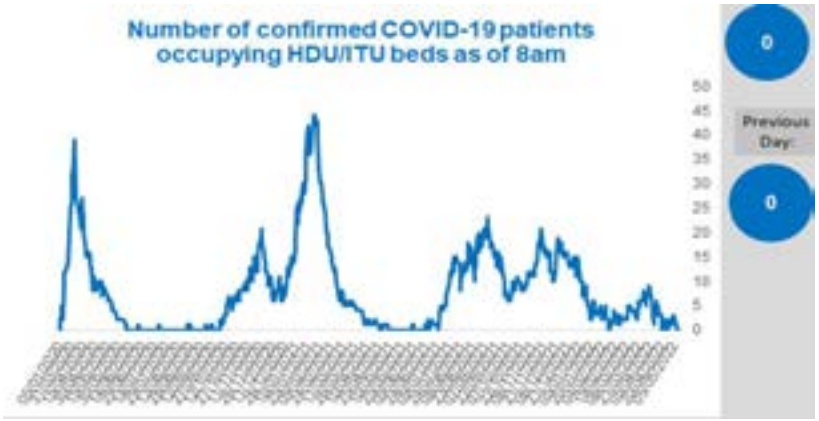
A&E - patients seen within 4 hours (NHSI)		⬇
Referral to treatment - % Incomplete pathways <18 wks (NHSI)		⬇
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)		⬇
Diagnostic tests longer than the 6 week standard (NHSI)		⬆
Dementia Find (NHSI)		⬇
Number of Clostridium Difficile cases reported		⬆
Cancer - Two week wait from referral to date 1st seen		⬇
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		⬇
Cancer – 28 day faster diagnosis standard		⬆
Cancer - 31-day wait from decision to treat to first treatment		⬇
Cancer - 31-day wait for second or subsequent treatment - Drug		⬆
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		⬆
Cancer - 31-day wait for second or subsequent treatment – Surgery		⬆
Cancer – 62-day wait for first treatment – screening		⬇
Cancer - Patient waiting longer than 104 days from 2 week wait		⬆

On the day cancellations for elective operations		⬇
Cancelled patients not treated within 28 days of cancellation		⬇
Virtual Outpatient (Non-face-to-face) appointments		⬇
Bed Occupancy (Acute)		⬇
No Criteria to Reside - daily average - weekday (ICO)		
Number of patients >7 days LoS (daily average)		⬆
Number of extended stay patients >21 days (daily average)		⬆
Ambulance handover delays > 30 minutes		⬆
Ambulance handover delays > 60 minutes		⬆
A&E - patients recorded as greater than 60 min corridor care		⟷
A&E - patients with >12 hour visit time pathway		⬆
A+E Trolley waits> 12 hours from decision to admit		⬆
Care Planning Summaries % completed within 24 hours of discharge – Weekend		⬇
Care Planning Summaries % completed within 24 hours of discharge – Weekday		⬆
Clinic letters timeliness - % specialties within 4 working days		⬆

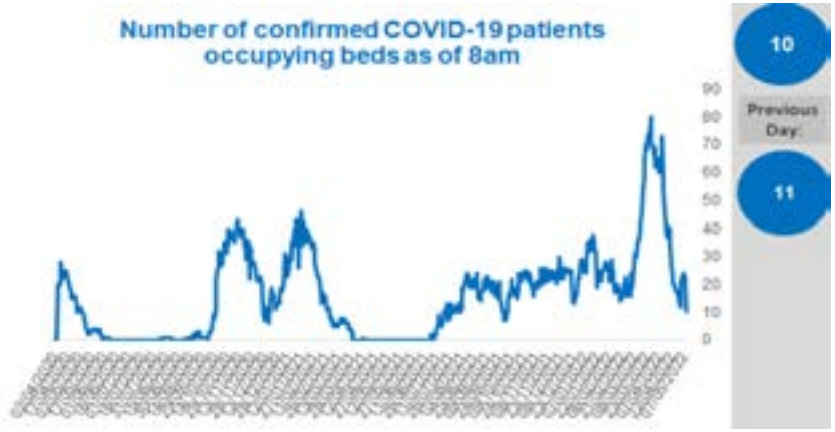
Covid - Hospitalisations

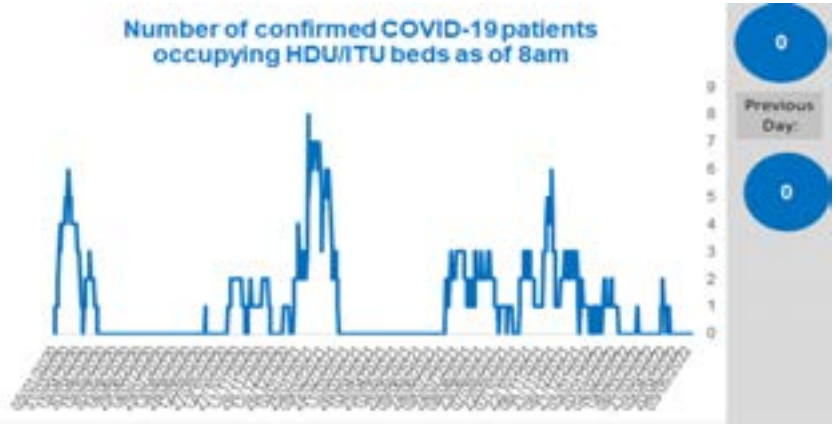
Devon ICS
(as at 12 May 2022)





Torbay and South Devon NHS FT
(as at 12 May 2022)





Throughout April, the Trust experienced a peak of covid hospitalisations, after a rapid increase in March, to a peak of 80 on 28th March, and falling to 10 by 16th May; the number of patients requiring intensive care however remained low reflecting reduced morbidity of covid infection.

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M1 58% Performance M12 58.4% Target 95% Risk level HIGH	The Emergency Department remains challenged with access to inpatient beds continuing to contribute long stays in the department overcrowding and ambulance handover delays. Ambulance handover delays remain very high with 680 patients experiencing over 60 minute delay compared to 19 patients last April. 656 patients experienced over 12 hours in the department compared to 14 last April. Across the wider system there continues to be capacity and workforce challenges to maintain the flow of patients out of hospital.	Streamlining GP referred emergencies to the Medical and Surgical Receiving units will reduce crowding in ED and ensure early specialist assessment. Triage is in place to risk assess all handover and ED delays for medical review. Tight infection control measures are mitigating the risk of Covid contact ad infection and the impact this can have on inpatient available beds. The Additional escalation beds opened in January have been fully utilised and remain in place. Work continues with system partners to support admissions avoidance and reduce delays to discharge patients when medically fit.	
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M1 50.38% Performance M12 52.67% Target 92% Risk level HIGH	The total number of people waiting for treatment has increased by 1,502 from last month. 779 patients are waiting longer that 78 weeks and 192 patients waiting longer than 104 weeks. All over-52-week waits have been validated by the Performance Team. Based on activity plans the overall waiting time forecast is not showing any reductions in RTT waiting times in the short term. Medium to longer terms plans will need to address the full backlog accumulated over the covid period. Critical to this will be the implementation of new models of care in the delivery of non-face-to-face consultations and capacity to address historical infrastructure and capacity constraints in theatres and diagnostics.	Operational focus continues on maintaining urgent and cancer related work. Patients will be booked in-line with clinical prioritisation Treatment capacity to target longest waits will be increased by: • Use of the Nightingale to provide 3 days operating June (2 days May) and adhoc sessions. • Additional insourcing to use main theatres and day unit at weekends; aim to start by end of May. • Teams reviewing plans to identify opportunities to increase capacity and productivity as part of the restoration of services and for 2022/23 business planning. • Mobile endoscopy room – still awaiting sign off. • Continue existing schemes with insourcing in ophthalmology and endoscopy.	 **Activity variance vs 2019/20 baseline** / **M12** / **M1** Op new / 22.8% / -16.3% OP Follow up / 19.6% / -13.4% Day Case / 16.2% / -17.7% Inpatient / -23.7% / -9.2%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	Performance M1 57.8% Performance M12 59.5% Target 85% Risk level HIGH	Performance against the 62-day referral to treatment standard remains below target. Capacity to support Urology 2ww and diagnostics remains highest overall risk along with endoscopy wait times. Maintaining 2 weeks urgent referral in Dermatology as the summer approaches with the seasonal increase in referrals is noted. Radiology waiting times have continued to increase with times for urgent appointments also extending. Medical oncology capacity is constrained due to the continued temporary change in location of the Day Unit.	Plans to reinstate elective day case capacity through the Day Surgery Unit commenced as planning on 25th April. This will allow increased treatment capacity for urgent treatments and diagnostic capacity to support cancer pathways Radiotherapy and medical oncology has continued to maintain timely access for treatment from diagnosis and treatment. Relocating the medical oncology day unit back to original location is now being Planned to complete in Q1. The COO is leading the process to sign off and review recovery plans through the Cancer Clinical Cabinet.	
Diagnostic tests longer than 6 weeks	Performance M1 33.9% Performance M12 36.8% Target 1% Risk level HIGH	Diagnostic waiting times for Endoscopy CT and MRI remain a risk to the timely treatment of cancer and urgent patients. Having no site for a mobile scanner on the DGH site remains a constraint for bringing in additional mobile capacity. Sickness, and recruitment remain critical factors in the current staffing pressures and to fully utilise fixed CT and MRI capacity. Insourcing for endoscopy is needed to maintain capacity however is becoming less effective with a higher rate of repeat investigations	The use of insourcing and mobile scanner units continue to support in-house capacity. Radiology (MRI) are using capacity at the Nightingale Hospital Exeter; currently 2-days a week, 160 patients per month). For endoscopy the plan is to move away from reliance on weekend insourcing and to provide inhouse capacity using a mobile endoscopy room. Pro-active recruitment and training initiatives continue to support teams that are operating with vacancies to minimise locum and bank staff.	

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M1	Performance against this indicator is reliant on support from a Health Care Assistant, performance will be impacted by annual leave and HCA availability.	The reliance on an HCA to support the dementia find process is being reviewed as part of the ward improvement work. Until a seamless electronic clinical record is available this may continue to require close operational support.	
	91.7%			
	Performance M12			
	93.6%			
	Target			
	90%			
	Risk level			
	LOW			

NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

April 2022 Incomplete 92% Table - National Speciality

	>126			
	Incomplete IPDC	Incomplete OP	Grand Total	% <18wks
Plastic Surgery	60	39	248	60.08%
Rheumatology	24	83	304	64.80%
Clinical Neuro-Physiology		131	204	35.78%
Nephrology		133	221	39.82%
Pain Management	48	200	499	50.70%
Endocrinology		361	684	47.22%
Neurology	19	849	1163	42.56%
Gynaecology	368	364	2324	68.50%
Respiratory Medicine	2	755	1547	51.69%
Gastroenterology	373	444	2255	63.77%
Colorectal Surgery	157	488	1518	44.33%
Dermatology	1	1088	2108	48.34%
Upper Gastrointestinal Surgery	479	643	1758	36.18%
Paediatrics	10	1153	2068	43.76%
Oral Surgery	439	1071	2798	46.03%
Cardiology	78	1471	3059	49.26%
ENT	209	1399	3008	46.78%
Urology	425	1301	2982	41.75%
Ophthalmology	344	1658	4579	56.72%
Trauma & Orthopaedics	1471	562	3687	44.88%
Grand Total	4554	14679	38763	50.63%

Referral to Treatment – incomplete pathways

Referral to Treatment: RTT performance in April has deteriorated slightly with the proportion of people waiting less than 18 weeks at 50.38% (unvalidated); this is behind the Operational Plan trajectory of 82% and national standard of 92%. We have continued to see an increase in the total number of incomplete pathways (waiting for treatment) to 38,763 (un-validated) from 37,261, an increase of 1,502 from the March position.

52 week waits: For April, 3,374 (unvalidated) people will be reported as waiting over 52-weeks and is an increase from 3,084. Overall long waits are increasing, with patients waiting longer than 78-weeks having increased slightly to 779 in April from 747, 104 weeks waits have decreased for the first time to 192 from 245 in March.

Recovery planning: DSU reopened on 24th April 2022 and MRU relocated to Level 2 Outpatients as planned; disruption continues to some services who required relocating from Level 2 Outpatients. The reopening of Day Surgery and the use of the protected beds on Ella Rowcroft has allowed teams to recommence operating on routine and long-wait patients. Activity levels are building but not yet back at pre-Covid levels. The CCG has restarted outsourcing to Mount Stuart Hospital for T&O and Gynae; but not long waiters. Approval has been given to bring a mobile Endoscopy van on-site located at the Annex; this will mitigate the loss of the MSH lists and bolster existing insourcing capacity; planned commencement for July/August with some enabling works to be completed. T&O continue to use lists at the recommissioned Nightingale Hospital Exeter with 2 all-day lists in May and 3 all-day lists in June. Further insourcing and outsourcing capacity is being sought through the Elective Recovery Fund (ERF) to use theatres on site at weekends for T&O (first lists on the weekend of 21st/22nd May), Urology, Upper GI, and Dermatology are still under discussion. Cataract operations have commenced at Optimax (privately provided ophthalmic theatre), further lists are being scheduled around surgeon availability.

Work continues to transform the outpatient model of delivery with a shift to increased non-face-to-face appointments, however, there remains more work to do with the percentage of non-face-to-face delivered outpatients being below national and local peers.

A trajectory to reduce the number of 104-week waits by the end of June 2022 has now been agreed with commissioners. This plan leaves a shortfall of 51 cases at the end of June and is reliant upon continued ringfence of elective capacity and commencement of insourcing at weekends. All options are being considered by the CCG including securing out of area independent sector capacity. The work across the Devon System to align capacity for elective and non-elective care will become increasingly relevant in the success of our recovery plans for 104-week waits and elimination of 78-week waits by March 2023.

Management Action: Led by the Chief Operating Officer, plans are monitored through the Cancer / RTT Performance Risk and Assurance meeting with any outstanding risk escalated to the monthly Integrated Governance Group (IGG).

The table below shows the specialties with the highest backlog for follow-up appointments greater than 6 weeks. April has seen an increase across all week bandings.

A process is in place to report to the Harm Review Group and Quality Assurance Group giving assurance with risk assessment against the cohorts of longest waiting patients by specialty.

The incident reporting process in Datix will be relied upon to document any actual harm that is encountered and this will again be reported through the Harm Review Group with appropriate Root Cause Analysis.

Specialtities with highest Follow-Up Backlog	Passed TBS as at 28.03.2022		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	864	1362	5845
Rheumatology	235	289	1335
Ear Nose Throat	237	263	1055
Paediatrics	179	231	628
Neurology	130	184	852
Orthoptist	237	272	494
Urology	63	56	296
Gynaecology	52	61	201
Respiratory Medicine (Chest)	124	276	322
Orthodontics	35	31	234
Colorectal Surgery	41	56	401
Orthopaedics	82	106	160
Dermatology	144	179	450
Geriatric Medicine	47	81	120
Cardiac Testing	24	30	21
Gastro-Enterology	124	178	230
Breast Surgery	21	27	296
Cardiology	108	164	168
Pain Management	46	41	80
Oral Surgery	66	108	140
Plastic Surgery			
Diabetic	78	74	65
Upper Gastrointestinal Surg	40	90	109
Respiratory Technician	53	29	196
Endocrinology	45	45	39
Grand Total	**3181**	**4334**	**13877**

Specialtities with highest Follow-Up Backlog	Passed TBS as at 03.05.2022		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	878	1394	6104
Rheumatology	194	352	1378
Ear Nose Throat	262	332	1156
Paediatrics	166	224	710
Neurology	133	212	895
Orthoptist	218	304	554
Urology	97	87	305
Gynaecology	48	47	220
Respiratory Medicine (Chest)	122	194	423
Orthodontics	52	44	223
Colorectal Surgery	34	61	408
Orthopaedics	115	99	192
Dermatology	155	208	521
Geriatric Medicine	55	49	140
Cardiac Testing	45	24	21
Gastro-Enterology	131	143	211
Breast Surgery	32	29	301
Cardiology	163	139	218
Pain Management	27	65	57
Oral Surgery	86	83	183
Plastic Surgery	41	68	82
Diabetic	63	79	71
Upper Gastrointestinal Surg	33	61	127
Respiratory Technician	7	62	224
Endocrinology	47	51	45
Grand Total	**3267**	**4437**	**14812**

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
259	32	259
43	63	43
101	69	101
82	-7	82
43	28	43
60	32	60
9	31	9
19	-14	19
101	-82	101
-11	13	-11
7	5	7
32	-7	32
71	29	71
20	-32	20
0	-6	0
-19	-35	-19
5	2	5
50	-25	50
-23	24	-23
43	-25	43
82	68	82
6	5	6
18	-29	18
28	33	28
6	6	6
935	**103**	**935**

NHSI indicator - 4 hours - time spent in Accident and Emergency Department

A&E and MIU patients seen within 4 hours

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Patients	7947	8802	9622	9536	9072	8738	8415	7483	6923	7201	6819	7974	8021
4 hour breaches	1238	1860	2636	2990	2935	3052	3155	3010	2596	2800	2690	3316	3370
% seen within 4 hours	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%
National target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Local trajectory	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Performance 4 hour standard: Performance has deteriorated in March to 58%. Access to suitable inpatients beds has contributed to delays at peak times.

12 hour Trolley wait: 155 patients are reported as having a 12-hour trolley wait from decision to admit to admission to an inpatient bed.

Ambulance Handovers: 680 ambulance delays over 60 minutes and increase from 757 in March; and 967 ambulance handover delays of over 30 minutes a decrease from 1026 in March.

Patients with a greater than 12-hour visit time pathway: 656 patients had a greater than 12-hour visit time.

Corridor Care: No patients recorded as receiving corridor care.

Operational delivery:

The number of patients waiting for a suitable bed continues to be the challenge that prevents improvements in performance and timely treatment of urgent patients. The department is still regularly having patients staying over night and having to manage high levels of nursing care. With a higher acuity of patients presenting and less available space to assess and treat, the Emergency Department is making the best flexible use of space to provide safe care to patients. Staffing vacancies continue to be a challenge with reliance on bank and agency backfill.

As we move into the summer months the department will see an increase in minor injury patients. Plans are in place to optimise the use of Newton Abbot Urgent Treatment Centre and Minor Injury Units.

Escalation status

Opel status	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Opel 1	3	2	0	0	0	0	0	0	0	0	0	0	0
Opel 2	26	16	1	0	0	0	0	0	1	0	0	0	2
Opel 3	1	13	21	7	7	5	3	1	4	10	27	13	24
Opel 4	0	0	8	24	24	25	28	29	26	21	1	18	4
4-hour Performance (ICO)	84%	79%	73%	69%	69%	65%	62%	60%	63%	61%	61%	58%	58%
Bed Occupancy (Acute)	87%	92%	95%	95%	95%	94%	93%	93%	93%	93%	94%	95%	94%
Ambulance handover delays >1 hour	19	26	173	165	120	72	125	617	616	559	438	757	680
Dom Care - hours outstanding*	189	235	467	613	994	1,261	1,357	1,288	468	611	605.75	625.75	538.25
No Criteria To Reside - daily average (weekday)				45	58	56	62	66	88	101	80	70	70

* December 2021 count changed to only include outstanding hours where client without formal support and client receiving formal support not at home

Apr-21

Mo	Tu	We	Th	Fr	Sa	Su
			1	2	3	4
			2	2	1	1
5	6	7	8	9	10	11
2	2	2	2	2	2	2
12	13	14	15	16	17	18
2	2	2	2	2	2	1
19	20	21	22	23	24	25
2	2	2	2	2	2	2
26	27	28	29	30		
2	2	3	2	2		

Apr-22

Mo	Tu	We	Th	Fr	Sa	Su
				1	2	3
				4	4	4
4	5	6	7	8	9	10
3	3	3	3	3	3	3
11	12	13	14	15	16	17
3	3	3	3	3	3	2
18	19	20	21	22	23	24
2	4	3	3	3	3	3
25	26	27	28	29	30	
3	3	3	3	3	3	

In relation to overall system pressures the above ambulance response time have been included into the performance report to highlight the significant contribution handover delays can have on wider system resources, patient experience and safety. At TSDFT we continue to experience high levels of handover delays so impacting on the capacity for the ambulance service to maintain timely responses to urgent 999 calls and more routine responses. The charts above show the recent performance in the category 1 and 2 ambulance response times for the SWAST headline performance. It is noted that the category 2 response times have improved to a mean of 1 hour compared to 2 hours reported in March. Both category 1 and 2 remain above target response times.

Category 1 calls being the 999 highest priority for immediate life threatening conditions with a target response time of 7 minutes
Category 2 calls being serious condition such as stroke or chest pain with a target response time of 18 minutes

Cancer treatment and cancer access standards

As at 17.05.2022	2022											
	Q4								Q1			
	February				March				April			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	795.0	853.0	1,648.0	48.2%	1,060.0	684.0	1,744.0	60.8%	1,048.0	711.0	1,759.0	59.6%
14 day - Breast Symptomatic Referral	45.0	18.0	63.0	71.4%	34.0	8.0	42.0	81.0%	43.0	13.0	56.0	76.8%
28 day - Faster Diagnosis Standard	1,219.0	455.0	1,674.0	72.8%	1,212.0	419.0	1,631.0	74.3%	1,163.0	350.0	1,513.0	76.9%
31 day - 1st Treatment	170.0	4.0	174.0	97.7%	181.0	4.0	185.0	97.8%	162.0	13.0	175.0	92.6%
31 day - Subsequent Treatment - Drug	69.0	0.0	69.0	100.0%	78.0	0.0	78.0	100.0%	68.0	1.0	69.0	98.6%
31 day - Subsequent Treatment - Radiotherapy	57.0	1.0	58.0	98.3%	48.0	3.0	51.0	94.1%	36.0	2.0	39.0	94.7%
31 day - Subsequent Treatment - Surgery	25.0	2.0	27.0	92.6%	38.0	5.0	43.0	88.4%	20.0	0.0	20.0	100.0%
31 day - Subsequent Treatment - Other	31.0	0.0	31.0	100.0%	16.0	0.0	16.0	100.0%				
62 day - 2ww referral	57.5	47.5	105.0	54.8%	73.5	45.5	119.0	61.8%	61.0	44.5	105.5	57.8%
62 day - Screening Referral	6.0	1.0	7.0	85.7%	8.0	1.0	9.0	88.9%	9.5	4.0	13.5	70.4%
62 day - Consultant Upgrade	1.0	0.0	1.0	100.0%	1.0	0.0	1.0	100.0%	0.0	0.0	0.0	0.0%

Cancer standards The table above shows the position for April 2022 (as at 16th May 2022). *Final validation and data entry is completed for national submission, 25 working days following the month close and at the end of the quarter.*

Urgent cancer referrals 14 day 2ww: 59.6% (unvalidated) is below the standard of 93%. Skin breaches continue to reduce with waits currently at 1 weeks and 6 days. Breast breaches have increased again (currently booking at 4wks), Urology Waits (7wks) and LGI waits (6wks) continue to impact. The most challenged pathways in April are Breast (25%) 143 breaches, Urology (33%) 84 breaches, LGI (40%) 167 Breaches, H&N (65%) Skin (69%) 213 breaches and Lung (76%) 10 breaches.

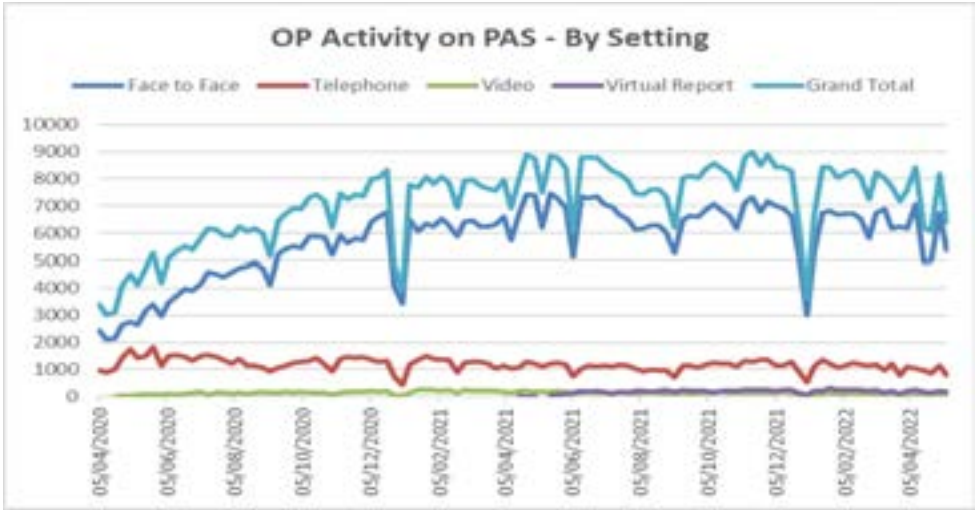
28 days From Referral to Diagnosis: Performance in March is 76.9% (unvalidated) against the target of 75%, this being a further improvement on March (75.0%) and reflects the breach reductions in the key specialities for LGI (137), Urology (58), Gynae (49), Skin (41) and Breast (30).

NHSI monitored Cancer 62 day standard: The 62-day referral to treatment standard has deteriorated slightly in April at 57.8% (unvalidated) against the target of 85% with 60 patient being seen within 62 days, however, 45.5 patients falling outside the target time; Skin account for 17 breaches, Urology 12 breaches, LGI 6 breaches and Breast 4 breaches and account for 86% of all breaches.

104-day wait: Currently there are 33 (unvalidated) patients with a greater than 104-day wait in April, an improvement from the 39 in February. 7 patients in the backlog having confirmed cancer. All of the long wait patients are reviewed by the cancer team with pathway queries escalated to operational teams and the RTT Risk and Performance Assurance Group. Urology remain the most challenged with 20 patients waiting longer than 104 days, 6 with confirmed cancers.

Virtual appointments (Non-face-to-face)

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
New	14.0%	15.0%	9.0%	14.0%	14.5%	12.4%	11.3%	14.30%	13.5%
Follow-UP	22.0%	21.0%	21.0%	21.0%	23.6%	21.7%	24.0%	23.90%	20.6%
Combined	**20.0%**	**19.6%**	**20.3%**	**20.5%**	**21.1%**	**19.3%**	**20.7%**	**21.30%**	**18.8%**



High Level Milestones	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Virtual Consultation Data - establish accurate recording and range of services.								
Review of current virtual appointments per service- • what is going well and why, and the learning from this shared • barriers to change, particularly for services reporting the lowest numbers and steps to address this.								
Communication and engagement around ambitions for Patient centred outpatients and review of what services are already doing to achieve this and map trust offer and use for gap analysis across services								
Establish clear processes, SOPS and clinical guidance to Virtual Consultations - focus on implementation, check and challenge through the PCO Board.								
25% of outpatient activity is completed virtually								

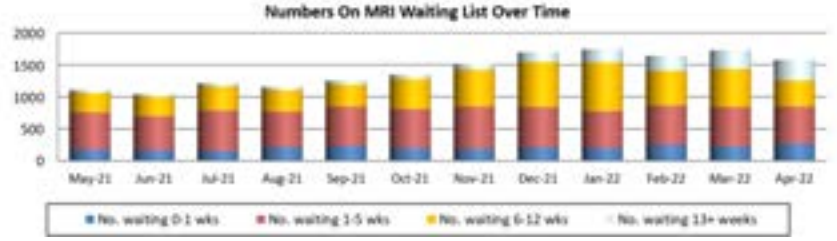
The Trust continues to see virtual appointment performance below the nationally set requirement achieving 18.8% in March against the target of 25% and the lowest in the Devon providers. Achieving 25% at Integrated Care System level is linked to achieving financial incentives into the Elective Recovery Fund and remains one of the business planning standards.

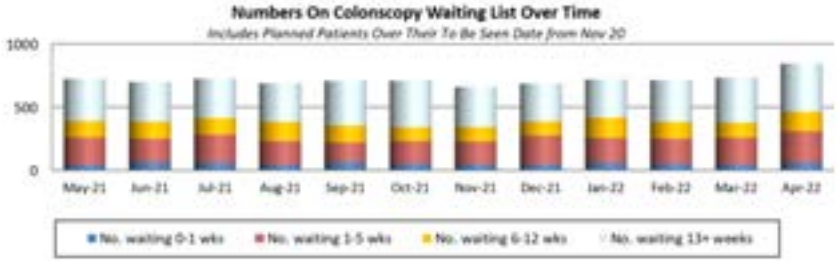
The Outpatient Transformation Programme has set out its programme of work (summarised opposite) to deliver improvement for the Virtual appointment targets of 25% from September 2022.

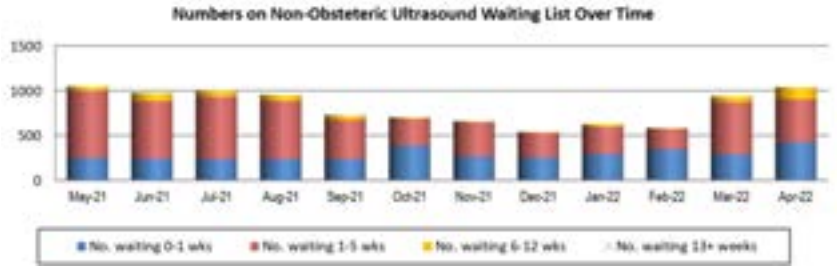
There is a scheduled programme of in-depth specialty reviews with clinical and operational teams. The ongoing escalation for covid has been a challenge between February 22/April 22 with the focus on maintaining most critical service capacity. The impact of recovery priorities for the most urgent care also increases the demand for direct hands on consultations. Opportunities are, however, being identified to increase outpatient utilisation and productivity. A number of activities recorded on other clinical systems (InfoFlex and community systems) are also being identified where non-face-to-face clinical activity is captured and needs be reported in our national returns. A Task and Finish group has been established to review and set out a workplan to ensure all 'in scope' outpatient data is collected and reported.

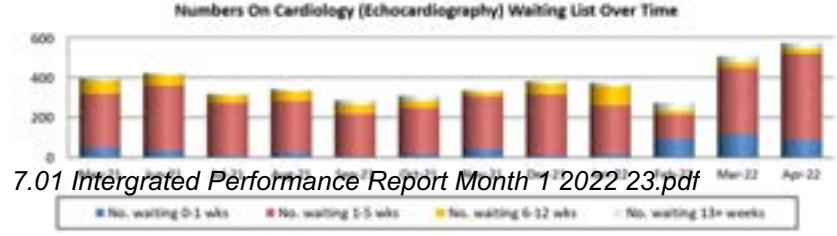
Use of Advice and Guidance, Patient Initiated Follow up and referral optimisation are all showing progress against March 2023 targets.

NHSI indictor - patients waiting over 6 weeks for diagnostics









Diagnostic tests longer than the 6 week standard

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Patients	4876	4909	4702	5682	5655	5542	5591	5848	5899	6162	5862	6503	6150
Waiting longer than 6 weeks	1768	1478	1516	1799	1821	1808	1888	1894	2237	2546	2250	2317	2080
% over 6 weeks	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	41.3%	38.4%	36.8%	33.9%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local trajectory	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

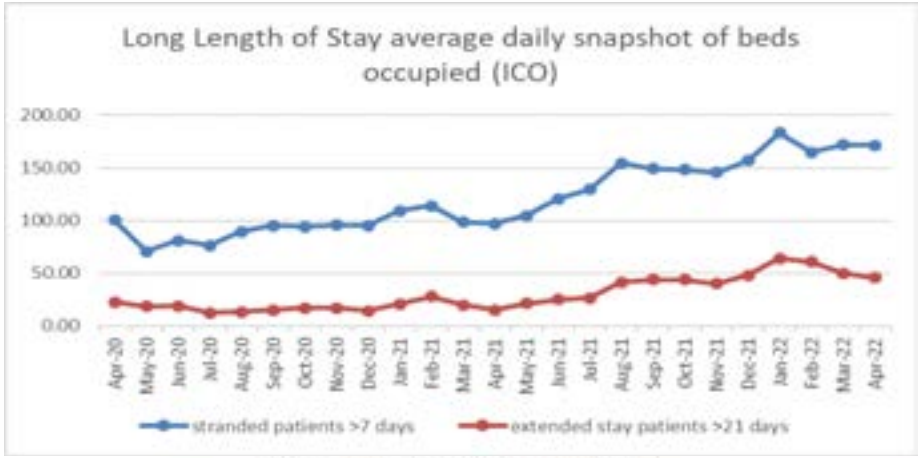
All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

MRI waits and total numbers on the list have improved with 732 (889 in March) over 6 weeks. The modality continues to see demand and capacity pressures. Capacity is reliant on the support of mobile scanner visits and the use of Nightingale with all in-house scanner capacity being utilised. Access for mobile scanning units to increase capacity is limited as only one mobile pad available and needed for mobile CT.

CT numbers waiting and waiting times for routine tests have stabilised but remain above target with 387 patients (634 in March) waiting over 6 weeks. There are increasing staffing pressures to maintain capacity for in-house scans, reporting, and vetting of referrals. Insourcing using mobile units will continue to support capacity (will be reducing going forward). Additional capacity at the Nightingale Hospital is planned to start at the end of May with contrast capability now being available. Radiographer vacancies continue to limit the ability to fully utilise in-house scanner capacity.

Colonoscopy numbers and routine waiting times increasing, with 535 over 6 weeks. Weekend insourcing continues but is becoming less effective as different teams are attending. A mobile endoscopy unit is scheduled to commence in July/Aug to offset the cessation of insourcing sessions at Mount Stuart Hospital. This will then give capacity needed to stabilise increases in waiting times. Urgent cancer pathways continue to be prioritised.

Access to diagnostics, and in particular radiology, is critical for maintaining timely cancer diagnosis and supporting treatment pathways. Whilst teams continue to prioritise urgent referrals it does mean that overall some patients will wait longer for routine diagnostic tests.



Long Length of Stay (LOS)

The average number of patients counted as having long length of stay greater than 7 and 21 days as measured in a daily census remains high. The number of patients experiencing long LOS is a critical measure as the Trust is challenged to maintain the flow of urgent patients through a fixed number of beds. Many of these patient will be included in the daily list of patients identified as "no criteria to reside" and on complex discharge pathways (P1-3) so subject to capacity pressures across the wider independent care sector.


Care Plan Summaries completed within 24 hours of discharge - Weekday

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Discharges	1434	1484	1474	1341	1288	1424	1263	1347	1239	1024	1052	1175	1271
CPS completed within 24 hours	869	883	848	812	553	1101	941	979	781	709	791	847	904
% CPS completed <24 hours	60.6%	59.5%	57.5%	60.6%	96.1%	77.3%	74.5%	72.0%	63.0%	69.2%	75.2%	72.1%	71.1%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%

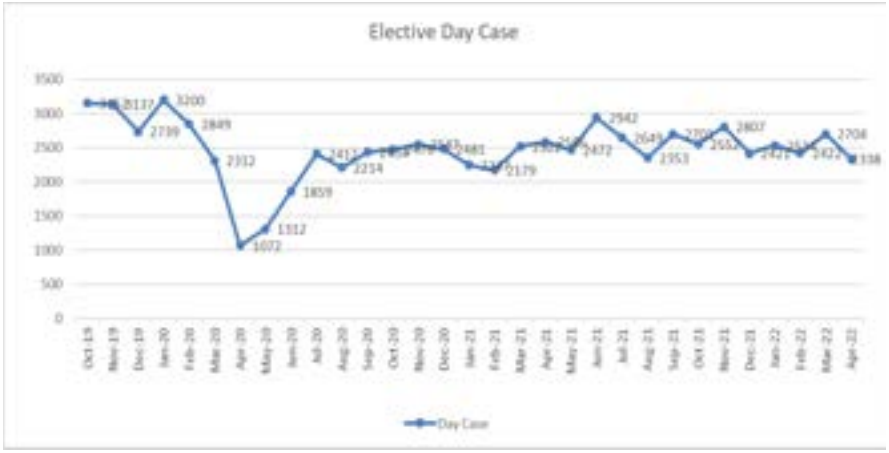
Care Plan Summaries completed within 24 hours of discharge - Weekend

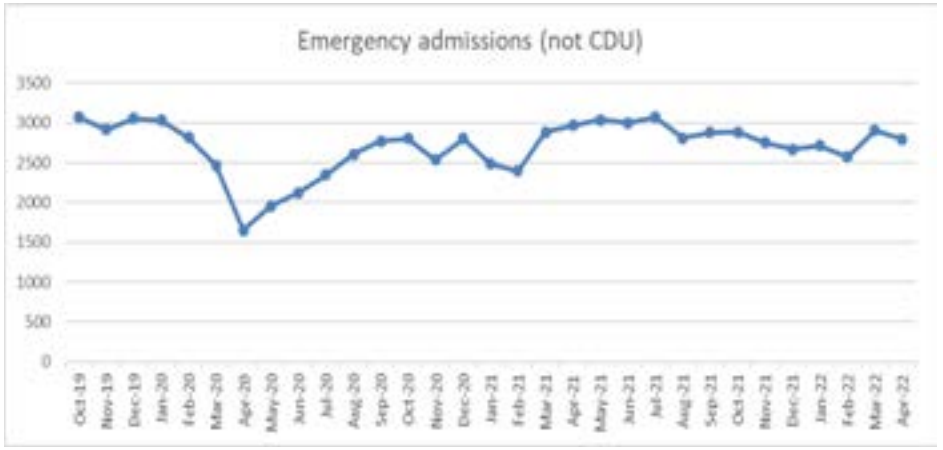
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Discharges	318	420	339	342	341	267	374	294	263	305	254	251	278
CPS completed within 24 hours	81	139	110	117	159	124	170	149	103	112	138	122	139
% CPS completed <24 hours	25.5%	33.1%	32.4%	34.2%	46.6%	46.4%	45.5%	50.7%	39.2%	36.7%	54.3%	48.6%	50.0%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

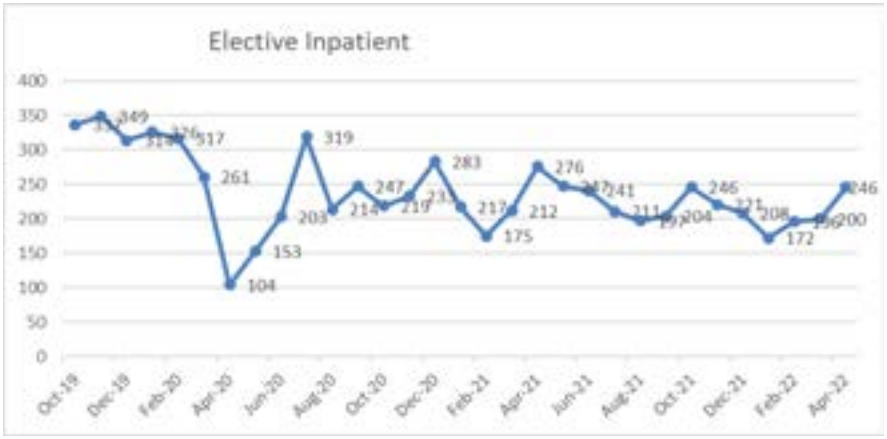
Care Planning Summaries (CPS)

Hospital Care Planning Summaries serve as the primary documents communicating a patient's care plan to the post-hospital care team. CPS completion (within 24 hours of discharge) has improved over the year.

Headline acute activity comparisons 2019/20 v 2020/21







The charts above show the monthly activity run rate of reported contract activity (Payment by Results & Cost and Volume) to end of April 2022. The 2019/20 pre-covid level comparisons for April are: Day case 82% Elective inpatient 91% Outpatient new 84% non elective admissions 97%

The reopening of the Day Surgery Unit and return of elective beds will contribute to an increase in both day case and elective activity in Month 2. The Trust is also now utilising capacity and the Nightingale Hospital Exeter and continuing to use insourcing at weekend across ophthalmology and endoscopy day cases. As part of the wider recover plans teams are planning to achieve in excess of 100% 19_20 activity levels.

The plan to have no over 104 week waits by end of June is progressing with a forecast of 61 cases remaining should all current plans deliver. The position is tracked on a daily basis. To support this plan the Trust is establishing arrangements to further increase insourcing at weekends in the longest waiting specialties of Orthopaedics Urology and Upper GI.

The Children and Family Health Devon report performance exceptions and operational variances through the monthly Integrated Governance Group (IGG) (TSDFT) and the Alliance Partnership Board.

CFHD

- We will commence discussions in June 2022 regarding the streamlining of reporting forums to increase CFHD capacity.
- Workforce consultation underway and should move into mobilisation June 2022. Mobilisation dependent on System One.
- CFHD have experienced increased sickness rates during Spring 22 which has impacted on capacity in SPA.
- Inter-operability issues having a significant impact on capacity.

Integrated therapies and nursing

- Several leadership vacancies in IT&N.
- Recovery plans for Autistic Spectrum Disorder (ASD) waiting times have progressed positively and will be extended into Q3, funded from underspend.
- Progress is positive with a sustained downward trend evident with 1k less CYP waiting than January 21. Reporting to NHS England and the Clinical Commissioning Group (CCG) continues fortnightly. An integrated virtual/core model has been developed which is robust and efficient.
- Speech and Language Therapy (SLT) remains the greatest challenge on reducing waiting times for treatment and this is compounded by the recent secondment of the SLT lead. Agency and bank continue to be explored. Additional resources have been identified by LA and CCG and a wait time initiative is developed but pending recruitment of staff.
- Additional investments for Occupational Therapy were only partially operationalised in 20-21 due to significant challenges in service lines and availability of bank and agency staff.

CAMHS

- The CAMHS Service remains under pressure due to staff vacancy and recent increased levels of demand. Vacancy rates in CAMHS appear to have stabilised and are more in line with trust norm's. Service leads are fully sighted on the challenges and action plans are closely monitored. CAMHS waiting times have been published in the local press.
- Additional monies for crisis, easting disorder, and mental health in schools has been awarded and the service model developed, go live for these developments in April 2022

Estates

Work being undertaken to model the estate capacity for both clinical and administration functions, options include co-location of CFHD within an Exeter base.

Children and Family Health Devon – Referral to Treatment

	Number of children waiting over 52 weeks for first definitive treatment		Percentage of routine referrals for CYP who are on an incomplete pathway within 18 weeks		Total number on caseload	
	FY 2021 April	FY 2022 April	FY 2021 April	FY 2022 April	FY 2021 April	FY 2022 April
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	239	281
Learning Disability (CFH Devon)	0	0	96.6%	100.0%	320	271
Mental Health and Wellbeing	1	17	64.2%	69.0%	3738	4092
Occupational Therapy (CFH Devon)	0	1	48.5%	64.9%	1171	1211
Palliative Care (CFH Devon)	0	0	NA	NA	38	43
Physiotherapy (CFH Devon)	1	0	81.5%	74.7%	409	531
Special School Nursing (CFH Devon)	0	0	NA	NA	412	472
Specialist Autism Spectrum Assessment Team (CFHD)	827	1856	23.8%	17.4%	2265	3755
Specialist Children's Assessment Centre (CFHD)	5	114	50.2%	38.2%	606	1003
Speech & Language Therapy (CFH Devon)	15	316	53.0%	42.7%	3928	5045

Financial Performance – Month 01 (April)
FY 2022 / 23

Financial Overview – Month 01, April 2022

High Level Summary

For Period ended - 30 April 2022, Month 01	Plan £m	Actual £m	Variance £m
Total Operating Income	46.49	46.99	0.50
Total Operating Expenditure and Financing Cost	(49.97)	(50.46)	(0.49)
Surplus/(Deficit)	(3.47)	(3.47)	0.00
Add back: NHSE/I Adjustments	0.07	0.08	0.01
Adjusted Surplus/(Deficit)	(3.40)	(3.39)	0.01
CIP	1.81	0.00	(1.81)
Capital	3.43	3.49	0.06
Cash & Cash Equivalents		29.69	

Adjusted Surplus / (Deficit)

In Month 1 (April) the Trust recorded materially balanced position against a planned deficit of £3.40m

Operating Income
Operating income for the year to date totals £46.99m, within which income for patient care activities totals £42.83m. Total income for the year to date is £0.5m favourable to plan. Key drivers are as follows: Non-patient services, education and training (£0.23m favourable), the remainder relates to other NHS income from the commissioners.

Operating Expenditure
Total operating expenditure and financing cost of £50.46m against the budget £49.97m with an adverse variance of £0.50m. Key drivers are as follows:

- Employee expenses £1.14m adverse mainly due to the non-delivery of CIP target in month £1.3m.
- Other operating expenses are favourable £0.45m mainly due to business rates (£0.51m favourable). In month CIP target of £0.41m has not been transacted and has been unofficially mitigated by underspends.

CIP Summary
CIP target at M1 was £1.81m, no formal transactions have been recorded this month against CIP delivery. This indicates non-recurrent mitigations have taken place either within the ISUs due to delays in spending plans, or via reserves.

Capital
Capital expenses totalled £3.49m in month which is slightly ahead of the planned expenditure value of £3.43m

Cash
The Trust is showing a cash position of £29.69m at the end of Month 01.

I&E Position – Month 01, April 2022

Income & Expenditure – Performance versus Plan

£m	M01 - In Month		
	Budget	Actual	Variance
Patient Income - Block	31.57	31.47	(0.09)
Patient Income - Variable	4.14	4.10	(0.05)
ERF/ERF+/TIF/Capacity Funding	0.06	0.00	(0.06)
ASC Income - Council	4.67	4.67	0.00
Other ASC Income - Contribution	1.02	0.96	(0.05)
Torbay Pharmaceutical Sales	1.58	1.41	(0.17)
Other Income	3.21	4.12	0.92
Covid19 - Top up & Variable income	0.26	0.26	0.00
Total (A)	**46.49**	**46.99**	**0.50**
Pay - Substantive	(24.52)	(25.13)	(0.61)
Pay - Agency	(0.61)	(1.15)	(0.54)
Non-Pay - Other	(12.77)	(12.07)	0.70
Non- Pay - ASC/CHC	(9.41)	(9.66)	(0.24)
Financing & Other Costs	(2.65)	(2.46)	0.19
Total (B)	**(49.97)**	**(50.46)**	**0.49**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**(3.47)**	**(3.47)**	**0.01**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.07	0.08	**0.01**
Adjusted Financial performance - Surplus / (Deficit)	**(3.40)**	**(3.39)**	**0.01**

System	Description	M01 Budget	M01 Actual	M01 Variance
Children and Family Health Devon (CFHD)	Income from patient activities	24.82	30.74	5.92
	Other Operating Income	0.43	0.65	0.22
	Operating expenditure - Pay	(9.90)	(9.73)	0.18
	Operating expenditure - Non Pay	(15.35)	(20.35)	(5.00)
Children and Family Health Devon (CFHD) Total		(0.00)	1.33	1.33
Pharmacy Manufacturing Unit	Income from patient activities	0.36	0.56	0.20
	Other Operating Income	15.80	14.68	(1.13)
	Operating expenditure - Pay	(7.75)	(7.15)	0.60
	Operating expenditure - Non Pay	(9.56)	(9.25)	0.31
	Finance expenditure	(0.14)	(0.14)	0.00
	Misc non-operating items	(0.10)	(0.10)	0.00
Pharmacy Manufacturing Unit Total		(1.41)	(1.40)	0.01
Shared Operations	Income from patient activities	7.10	7.10	0.00
	Other Operating Income	0.33	0.25	(0.08)
	Operating expenditure - Pay	(8.14)	(8.03)	0.11
	Operating expenditure - Non Pay	(1.47)	(2.58)	(1.11)
Shared Operations Total		(2.18)	(3.26)	(1.08)
Shared Corporate Services	Income from patient activities	355.49	371.15	15.66
	Other Operating Income	18.05	18.56	0.51
	Operating expenditure - Pay	(89.55)	(106.85)	(17.30)
	Operating expenditure - Non Pay	(63.99)	(40.54)	23.46
	Finance expenditure	(0.83)	(0.74)	0.08
	Finance income	0.00	0.24	0.24
	Misc non-operating items	(5.68)	(5.67)	0.02
Shared Corporate Services Total		263.56	286.16	22.60
South Devon	Income from patient activities	6.34	0.79	(5.55)
	Other Operating Income	1.59	1.66	0.07
	Operating expenditure - Pay	(103.10)	(104.26)	(1.16)
	Operating expenditure - Non Pay	(21.15)	(23.85)	(2.69)
	Finance expenditure	(1.54)	(1.54)	0.00
South Devon Total		(117.86)	(127.59)	(9.73)
Torbay	Income from patient activities	29.40	18.01	(11.38)
	Other Operating Income	5.26	5.78	0.52
	Operating expenditure - Pay	(82.89)	(76.72)	6.16
	Operating expenditure - Non Pay	(128.58)	(137.41)	(8.83)
Torbay Total		(176.82)	(190.33)	(13.52)
Grand Total		(34.71)	(34.70)	0.01

In Month Position:

Income

- Overall patient income is £0.5m variable relating to the high CFHD contract this is matched by cost under non-pay.

Pay

- No pay award had been formally agreed in Month 1, the position includes the estimated 2% pay uplift for substantive and Bank staff.
- At M1 overall pay is overspent by £1.1m against the budget of £25.1m. mainly due to non-delivery of CIP target (£1.3m).
- M1 substantive staff group is overspent by £0.13m and bank £0.48m.
- Agency cost is £0.5m higher than budgeted with CIP. The overspend in Agency mainly relates Nursing (£0.26m) and medical (0.23m) staff groups.

Non-pay

- Non-pay overall is underspent by £0.6m underspend, mainly relates to a business rates adjustment and delays non-pay clinical consumable. The non-pay CIP target for April is £0.4m, which indicates other underspends are absorbing the CIP requirement.
- Higher costs of £0.5m relating to CFHD contract which is offset in patient income.
- Other material underspends include drug costs £0.19m and depreciation charges £0.23m
- ASC-CHC overspend £0.25m relates to an unachieved CIP requirement

Risks and Mitigations and Forward Look

Risks and Mitigations

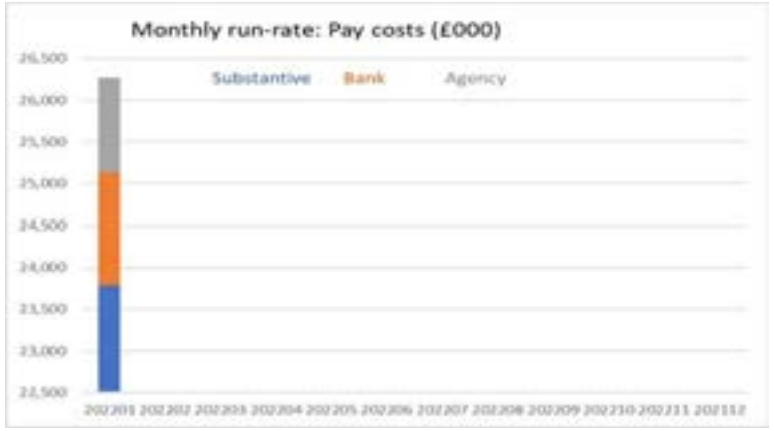
In month 1 there has been no CIP delivery formally transacted against a target of £1.8m, of which £1.3 relates to pay. This indicates that non-recurrently mitigations had taken place either within the ISU due to delays in spending plan, or via reserves. At this stage of the financial year, ISU's are expected to identify detailed delivery plans for CIP. Deloitte are also supporting ISU's in project implementation under a number of workstreams.

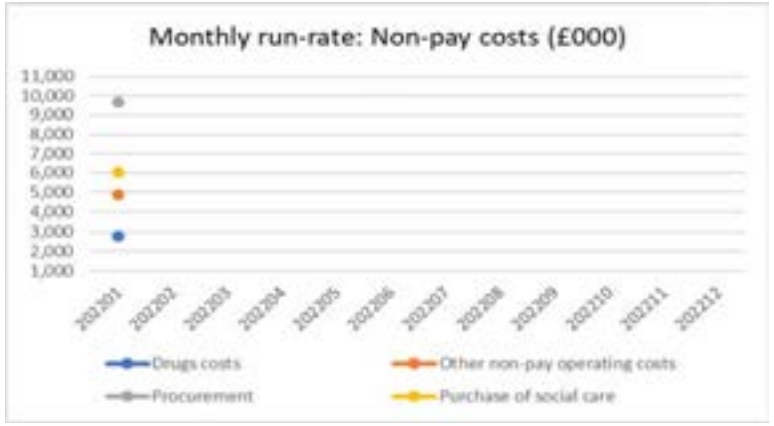
With regards to ERF income, no ERF income in April 22 had been recognised due to the delays in some of the schemes.

Forward Look

The Trust currently has a planned adjusted deficit of £29.9m for FY 2022/23.

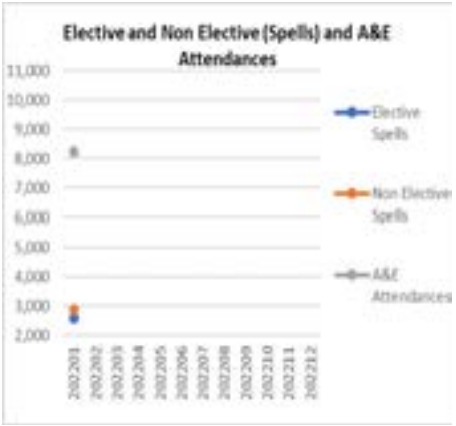
- The planned deficit of £29.9m is after the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives. At this point in time delays had occurred against the originally planned phased delivery.
- The plan is currently not accepted to regulators and further improvement is underway at ICS level with 10 workstreams set-up to drive further opportunities, through consistency in approach and joined working. A plan resubmission in June has been requested.
- Contract agreement is underway between the ICS and providers with a simplified and compliant approach on marginal contract set-up for ERF, which would include potential mitigation in the first instance via ICS / S256.
- It is likely the Hospital Discharge programme will continue into 2022/33 supported by S256, however the exact period has not yet been defined.
- Capital plans for 2022-23 and beyond have been developed, there are significant pressures on CDEL allocation, further prioritisation is underway.

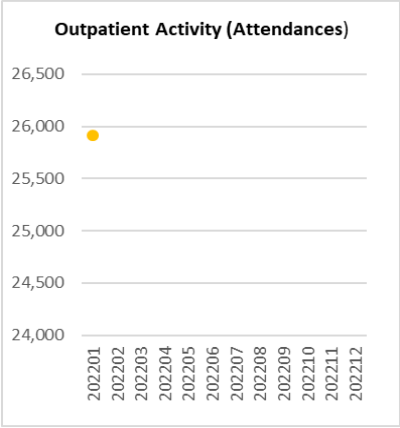




Change in Activity Performance – Month 12 to Month 01

		Plan M1	Mar-22	Apr-22	Variance to Plan	% Variance
Activity Drivers	A&E Attendances	8,485	7,085	8,238	-247	-3%
	Elective Spells	2,598	2,618	2,584	-14	-1%
	Non Elective Spells	3,299	2,829	2,875	-424	-15%
	Outpatient Attendances	26,532	26,484	25,915	-617	-2%
Bed Utilisation	Occupied beds DGH	0	10,798	10,465	0	0%
	Available beds DGH	0	11,359	11,164	0	0%
	Occupancy	0	95%	94%	0	0%
Resource Consumption	Medical Staff Costs - £000's	5,277	5,848	5,668	391	7%
	Nursing Staff Costs - £000's	5,833	6,326	6,227	394	6%
	Temp Agency Costs - £000's	612	1,467	1,147	535	36%
	Total Pay Costs - £000's	25,133	38,182	26,273	1,141	3%



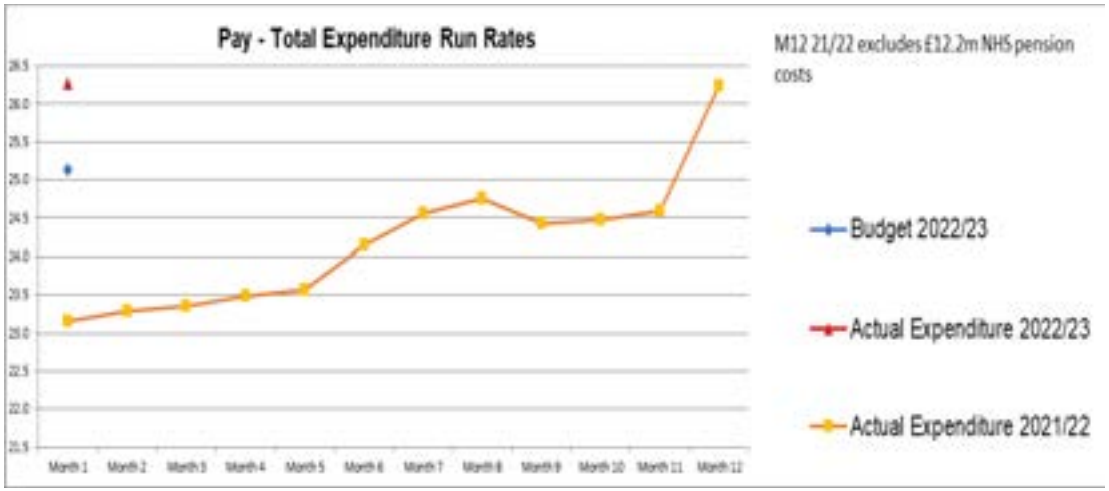


Activity Drivers

- ICS and providers are currently in the process of finalising the contract and activity plans.
- Overall, elective activity levels are broadly on plan at month 1, however, below plan for Outpatients. In comparison against 2019/20 (NHSE/I comparator year), the Trust achieved 85% overall Elective/Outpatient activity in month 1. Elective activity is currently planned to ramp up in Q1, achieving 100% of 19/20 levels from July 22.
- ISUs are continually looking at ways to increase their productivity, including making use of the additional ERF funding available to increase capacity to see more patients, reduce waiting lists and ensure patients are treated as quickly as possible.
- The Trust and ICS have created processes for recording and monitoring ERF costs and activity

Bed utilisation

- In April, the overall bed occupancy at 94% and remains above required levels to support timely patient flow to avoid emergency care delays and required the continued stepping down of routine elective surgery. Despite continued pressure from Covid-19 hospitalisations in April and associated infection prevention and control constraints we have seen a reduction in the number of patients identified as medically fit and having no criteria to reside in an acute hospital bed – This has reduced from an average of 65 January to 50 in April and has reduced further in May.
- Access to beds for medical and surgical emergencies has seen patients regularly staying overnight in assessment units and Emergency Department. This being a major factor in the continued high level of ambulance handover delays and long waits in the Emergency department. Trust has been in OPEL 3 escalation for most of the month.
- At the end of April, the relocation of the Medical Receiving Unit out of the Day Surgery department was successfully achieved along with the de-escalation of medical beds out of the orthopaedic surgical ward meaning elective surgery for routine surgical cases has now recommenced.



Pay Expenditure – Month 01, April 2022

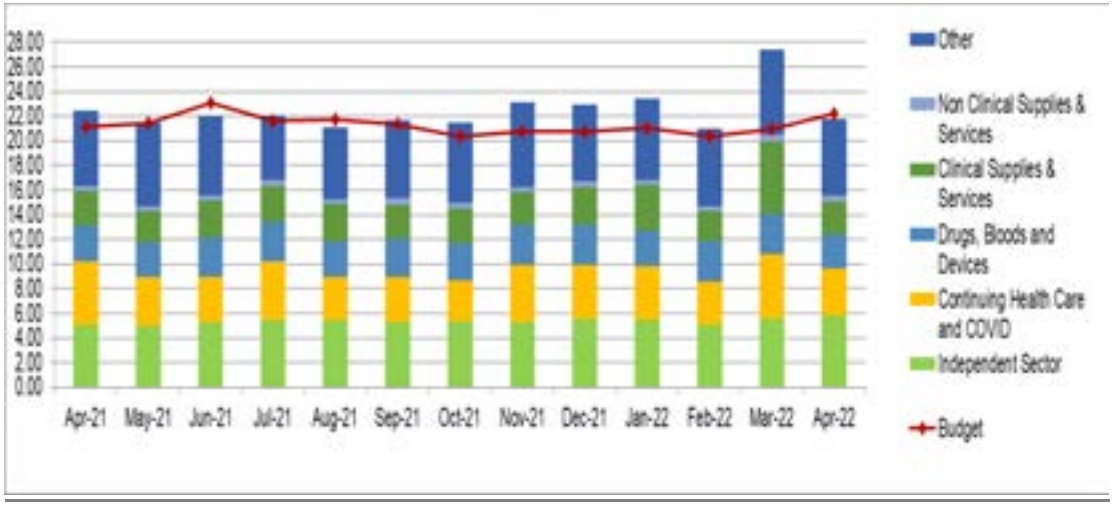
The total pay run rate in month 01 (£26.27m) is £0.04m lower compared to compared to Month 12 (£26.27m).

Compared to budget for month 01 pay is overspent by £1.14m, which includes non-delivery of CIP £1.30m.

Comparisons actual to budget for month 01 are as follows:

- Substantive pay is overspent by £0.13m
- Bank pay is overspent by £0.48m which is primarily in HCA (£0.23m), Medical staff (£0.14m) and Nursing (£0.06m).
- Agency costs are overspent £0.50m due to Nursing (£0.26m), Medical staff (£0.15m) and (£0.13m) over various clinical and admin roles, due to ongoing vacancies.
- The Apprentice levy balance at Month 01 is £2.32m (£2.29m in M12). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

Non-Pay Expenditure – Month 01, April 2022



The total non-pay run rate in Month 01 (£21.73m) is £5.66m lower in comparison to previous month (£27.38m), key details comparing to March run-rate are provided below:

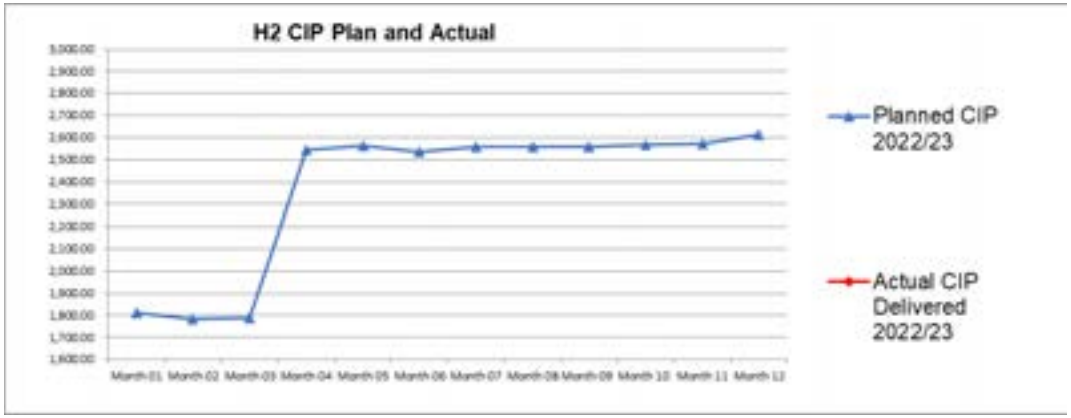
- Clinical supplies – net decrease of £1.77m, primarily medical and surgical supplies £1.47m, general and laboratory equipment £0.12m, contract maintenance £0.09 and TP cost of sales £0.30m offset by higher chemical consumables (£0.22m).
- Donated PPE / push stock from DH - £1.31m decrease from March.
- Drugs, bloods and devices net decrease £0.53m
- CHC related COVID cost – net decrease £1.20m – In financial year 21/22 there were a number of national (HDP) and local authority funded schemes to assist providers which were paid throughout the year, some of these had coming to an end.
- Placed People (including Continuing Healthcare) £0.24m April spend reduction in run rate due to additional costs to cover a specific package in March.
- Net Operating expenditure – net decrease £0.70m, primarily due to the business rates adjustment and premises costs (£0.38m) and a reduction in professional services (£0.38m)
- Adult Social Care (ASC) - £0.28m April spend is higher than March due to inflationary uplifts impacting the rates that are charged for packages of care.
- General supplies – £0.17m, non-healthcare service contract including records management (£0.06m), domestic cleaning mats and kitchen equipment (£0.05m) and uniforms (£0.03m).

Key Drivers of System Positions – Month 01, April 2023

System	ISU	Financial Commentary / Key Drivers
Children & Family Health Devon	CFHD	Budget has been set on model option 2 for 2022/23. As at Month 01, the Alliance generated a surplus and after the risk share calculation, TSD is benefiting from (£133k) surplus to the I&E. The actual expenditure run rate has remained constant. The proposed staffing model and clinical pathways consultation is live, with Senior Teams leading discussions on pathway options; this contributes to a current high level of vacancies which will not change until the consultation is concluded. SystemOne EPR revenue has been budgeted for but there is potential that the project may not commence until 2023/24 due to a change in TSD priorities and unavailability of IT resources; therefore no costs are currently expected in this financial year.
Torbay Pharmaceuticals	PMU	TP sales in M01 is 0.13m lower than plan primarily due to lower Non-NHS sales. Overall performance in moth is materially balanced, with a net loss in (£0.14m)
Corporate	EFM	Over spent at M01 by £538k. Pay is over spent by £273k due to the ceasing of additional working no longer recharged to Covid and a smaller amount of incentive payments paid. Non-pay is over spent by £66k due to repairs and maintenance contracts and external service agreements. Income is underachieved by £22k due to vacant staff accommodation and patient/visitor car parking charges. Unachieved CIP target of £178k, previously identified CIP has not been transacted in M01, plans are in place.
	Exec. Directors	Marginally underspent by (£67k). Pay and non-pay practically balance back to budget overall, with vacancies in HIS of (£79k) offset with £50k CEA award accrual and severance pay in Strategic Communications; and a reduction in Legal fees of (£29k) offset by international recruitment costs including travel. Income has overachieved by (£200k) mainly due to Q1 Health Education England (HEE) income regarding medical training and education. Unachieved CIP target of £124k
	Financing Costs	Excluding items outside the NHSE/I control total, costs are £0.1m favourable to plan. There are no noteworthy variances.
	Other	Reserves includes plan adjustments, provisions for FNC backlog, legal fees, miscellaneous and other small provisions.
South System	Coastal	Marginally underspent M1 by £90k. Pay is underspent £133k due to vacant posts, and non-pay underspent £60k medical and surgical. This is offset with £240k adverse CIP target. Pay run rates have increased M1 compare to an average of the previous quarter due to recruitment of vacant posts, and non-pay remains broadly in line with the previous quarter average spend. ERF recovery schemes are recorded centrally and not within this ISU.
	Newton Abbot	Overspent at M1 £469k. Mainly due to cost pressures in in ED and Acute Medicine. This is reflected by high Medical Locum and Bank and Nursing Agency and Bank spend: ED areas were overspent £256k and Acute Medicine (including all Gen Med Junior Doctors) by £128k, under delivery CIP £165k. This is offset by underspends in UTC, ICU, and vacant posts £83k. Increased run rate from previous month mainly in Acute Medicine temporary staffing costs.
	Moor to Sea	M1 break even position against budget, with ward underspends due to delayed recruitment, offset with adverse CIP target. Run rates are broadly consistent with previous quarter average excluding year-end adjustments.
	Shared Operations	Marginally underspent M1 £1k. Underspend in pay due to vacant posts, offset by adverse CIP target. Run rates are broadly consistent with previous quarter average excluding year-end adjustments.

Torbay System	Independent Sector	ISU has a YTD overspend of £100K which is unachieved savings.
	Torquay	ISU has a YTD overspend of £125K which is unachieved savings.
	Paignton and Brixham	Excluding IPAT ISU has an underspend of circa £200k. The underspend is pay related which is materially driven by £250K (Covid recovery ward) and £80K linked to consultant / locum vacancies.
Contract Income	Patient Income	The Trust has received the following income in M1: 1) No income assumed for Elective Recovery Funding. 2) C.£0.3m additional income assumed via the CCG relating to the Hospital Discharge Programme (HDP). There is a corresponding cost to offset this. 3) Nothing relating to grants has been received or assumed from Torbay Council.

CIP – Month 01, April 2022



CIP

The Trust's financial plan for 2022/23 requires the delivery of a £28.5m efficiency programme, which includes a £10.4m reduction in COVID related costs (compared to 2021/22). It should be noted that with regard to the latter, a planned re-investment of £5.3m to support the recovery of services has budgeted for.

Phased delivery of the efficiency plan for the first quarter is £5.4m, with planned delivery of £1.8m in each of Months 1, 2 & 3. Per the Trust's April planning submission, the split of the £1.8m target for Month 1 is:

- Pay related - £1.3m
- Non-pay related - £0.4m
- Income related - £0.1m

A number of the pay related efficiency schemes did not commence in Month 1. The Trust's actual financial performance for Month 1 would suggest a potential shortfall of £1.1m against the efficiency target, linked to the position on pay. However, slippage in other areas of spend, along with non-recurrent benefits, have mitigated any shortfall against the efficiency target in-month.

Cash Position – Month 01, April 2022

	Plan £m	M01 Actual £m	Variance £m
Opening cash balance	**39.34**	**39.34**	**0.00**
Capital Expenditure (accruals basis)	(3.43)	(3.49)	(0.05)
Capital loan/PDC drawndown	0.00	0.00	0.00
Capital loan repayment	0.00	0.00	0.00
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	(7.00)	(7.35)	(0.35)
Other capital-related elements	(0.26)	(0.62)	(0.36)
Sub-total - capital-related elements	**(10.70)**	**(11.46)**	**(0.77)**
Cash Generated From Operations	(0.82)	(1.01)	(0.19)
Working Capital movements - debtors	(0.35)	0.78	1.13
Working Capital movements - creditors	(1.26)	2.32	3.58
Net Interest	(0.26)	(0.18)	0.08
PDC Dividend paid	0.00	0.00	0.00
Other Cashflow Movements	(0.11)	(0.11)	0.00
Sub-total - other elements	**(2.79)**	**1.82**	**4.60**
Closing cash balance	**25.86**	**29.69**	**3.84**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	12,876	10,817	84.0%
Non-NHS - value of bills (£k)	33,478	28,664	85.6%
NHS - number of bills	240	155	64.6%
NHS - value of bills (£k)	3,993	2,466	61.8%
Total - number of bills	13,116	10,972	83.7%
Total - value of bills (£k)	37,471	31,130	83.1%

Key points of note:

- Capital-related cashflow is £0.8m adverse to plan. This is largely due to the paying down of the capital creditor (£0.4m adv).
- Working capital debtor movements is £1.1m favourable to plan. This is principally due to Other Current Assets being £1.7m lower than planned.
- Working capital creditor movements in £3.6m favourable to plan. This in principally due to Other Current Liabilities being £2.9m higher than planned.
- NHSE/I has indicated that there will be increased focus on the Better Payment Practice Code and options to improve performance are being reviewed and implemented.
- It should be noted that the Trust had submitted a Q1 interim PDC revenue cash support request to NHSEI flowing the deadline of 11th May to support the in-year deficit plan.

Statement of Financial Position (SoFP) – Month 01, April 2022

	Month 01		
	Plan £m	Actual £m	Variance £m
Non-Current Assets			
Intangible Assets	12.02	11.90	(0.11)
Property, Plant & Equipment	213.68	214.00	0.32
On-Balance Sheet PFI	17.57	17.55	(0.02)
Right of Use assets	24.14	24.51	0.37
Other	1.44	1.45	0.01
Total	**268.83**	**269.41**	**0.58**
Current Assets			
Cash & Cash Equivalents	25.86	29.69	3.84
Other Current Assets	41.59	39.89	(1.70)
Total	**67.45**	**69.58**	**2.14**
Total Assets	**336.28**	**339.00**	**2.71**
Current Liabilities			
Loan - DHSC ITFF	(3.87)	(3.87)	(0.00)
PFI / LIFT Leases	(1.31)	(1.31)	(0.00)
Trade and Other Payables	(60.28)	(59.82)	0.46
Other Current Liabilities	(13.76)	(16.64)	(2.88)
Total	**(79.22)**	**(81.64)**	**(2.42)**
Net Current assets/(liabilities)	**(11.77)**	**(12.06)**	**(0.28)**
Non-Current Liabilities			
Loan - DHSC ITFF	(25.21)	(25.21)	0.00
PFI / LIFT Leases	(15.18)	(15.18)	0.00
Other Non-Current Liabilities	(26.43)	(26.73)	(0.30)
Total	**(66.83)**	**(67.12)**	**(0.29)**
Total Assets Employed	**190.24**	**190.24**	**0.00**
Reserves			
Public Dividend Capital	150.33	150.33	0.00
Revaluation	51.54	51.54	0.00
Income and Expenditure	(11.63)	(11.63)	0.00
Total	**190.24**	**190.24**	**0.00**

Key points of note:

- Following the adoption of the IFRS 16 accounting standard on 1 April 2022, a separate category for Right of Use assets has been included within non-current assets.
- Cash is £3.8m higher than planned, as explained in the commentary to the cashflow statement.
- Other current assets are £1.7m lower than planned. This is principally due to reduced debtors with the CCG £1.3m.
- Trade and other payables are £0.5m lower than planned. This is principally due to capital creditors having been paid down £0.4m more than planned.
- Other current liabilities are £2.9m higher than planned. This is due to deferred income (eg HEE Q1 block income received in advance £2.0m).
- Other non-current liabilities are £0.3m higher than planned due to the recognition of lease dilapidation provisions.

Statistical Process Control (SPC) charts

It is understood that measurement is integral to the improvement methodology in healthcare but it is not always possible to see from the data if improvements are being made. There is an element of variation in the way services are delivered by individual departments, people, and different types of equipment.

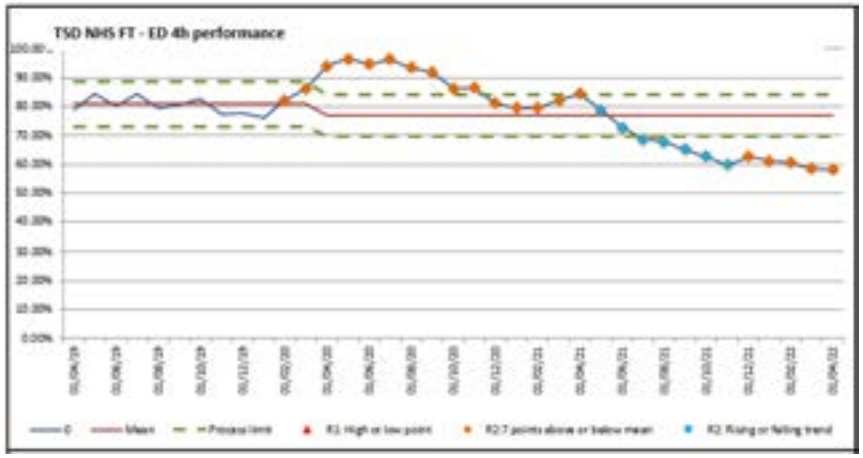
The main aims of Statistical Process Control (SPC) charts is to understand what is 'different' and what is the 'norm'. SPC charts can help to:

- 'predict' statistically whether a process is 'capable' of meeting a target;
- identify if a process is sustainable - i.e. are your improvements sustaining over time;
- identify when an implemented improvement has changed a process - i.e. it has not just occurred by chance;
- generally understand processes - helping make better predictions and thus improve decision making;
- recognise abnormalities within processes;
- understand that variation is normal and to help reduce it;
- prove or disprove assumptions and (mis) conceptions about services;
- drive improvement – used to test the stability of a process prior to redesign work, such as Demand and Capacity.

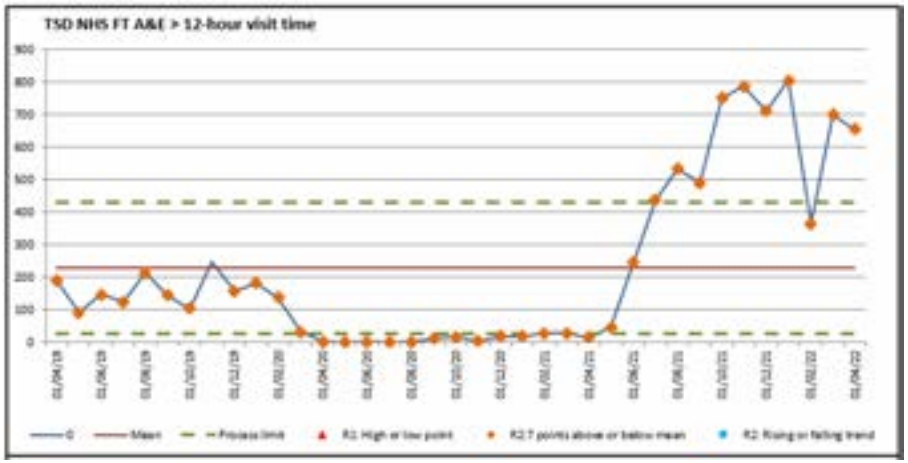
Control limits are the standard deviations located above and below the centre line of an SPC chart. If the data points are within the control limits, it indicates that the process is in control (common cause variation). If there are data points outside of these control units, it indicates that a process is out of control (special cause variation).

In preparing for fuller roll out, a selection of key metrics are presented below in SPC format.

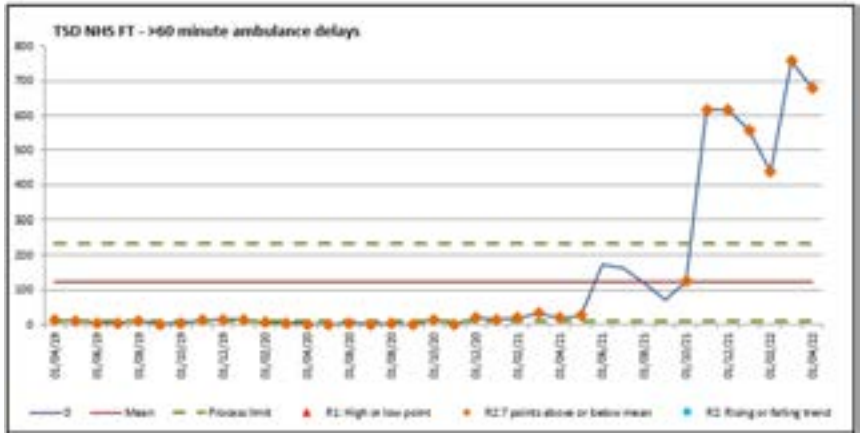
ED 4 hour performance



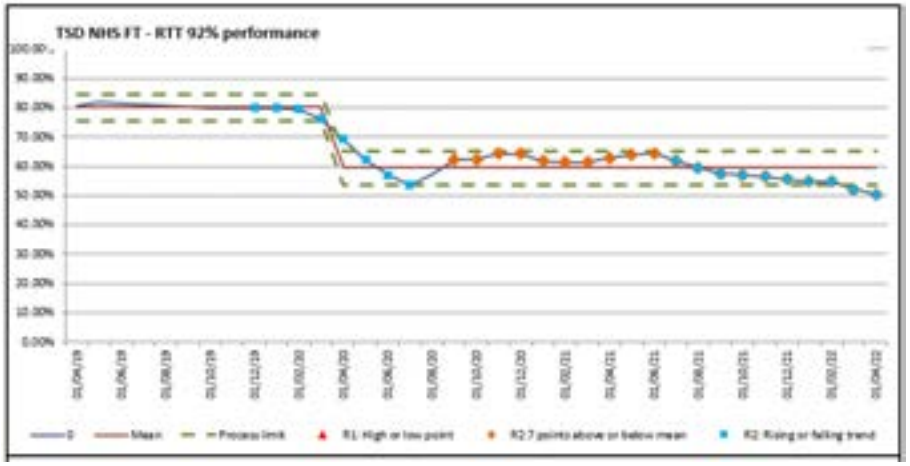
12- hour visit time



Greater than 60-minute ambulance handover delays

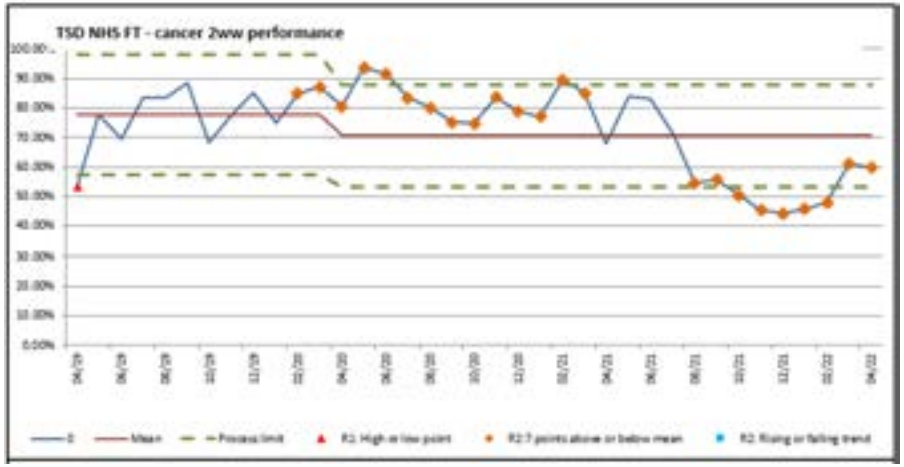


Referral To Treatment

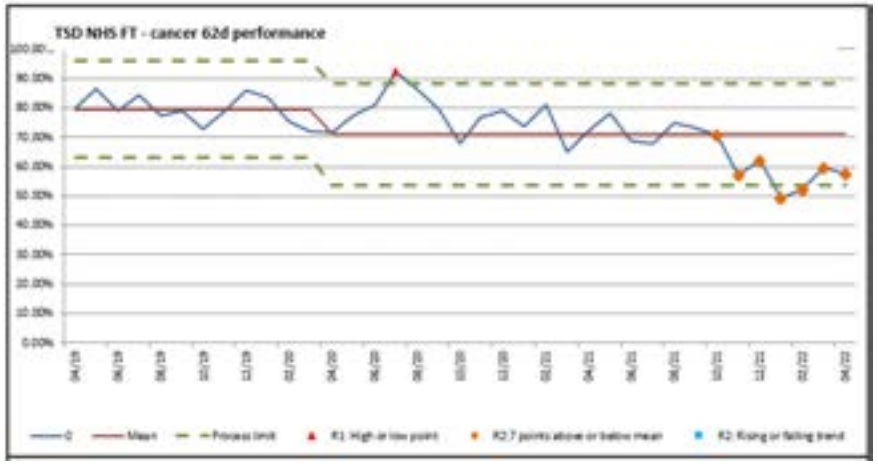


Diagnostics performance

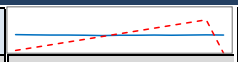
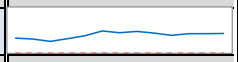
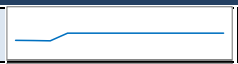
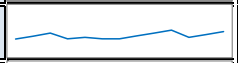
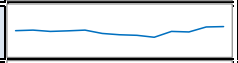
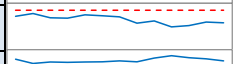
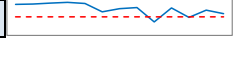
Cancer 2-week-wait performance



Cancer 62-day performance



	ISU	Target	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	2	4	2	2	0	1	3	0	4	4	4	2	2
Reported Incidents - Death	Trustwide	<1		0	2	1	2	0	0	1	5	0	2	0	3	2	2
Medication errors resulting in moderate harm	Trustwide	<1		0	1	1	0	0	0	0	0	0	1	1	1	1	1
Medication errors - Total reported incidents	Trustwide	N/A		50	64	57	47	38	47	58	46	59	43	56	54	57	57
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	1	0	2	0	0	1	1	0	0	0	1		0
Never Events	Trustwide	<1		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		5	7	11	8	8	6	1	12	12	6	13	9	8	8
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	2	0	0	0	2	1	0	0	0
Formal complaints - Number received	Trustwide	<60		10	9	15	18	17	11	11	10	9	16	11	12	12	12
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%	94.8%	95.2%	94.4%	91.3%	91.3%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		102.6	105.5	106.6	108	110.2	108.4	109.6	108.1	107.5	107.3				0
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		89.0%	90.2%	87.1%	89.5%	87.0%	81.9%	81.9%	89.3%	87.81%	86.8%	88.3%	90.0%	89.0%	89.0%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		90.3%	88.5%	89.4%	93.4%	88.0%	74.6%	74.6%	83.7%	60.32%	77.8%	78.8%	79.3%	79.7%	79.7%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		24	42	381	24	8	42	476	218	285	71	49	203	30	30
Hand Hygiene	Trustwide	>95%		96.0%	94.8%	97.6%	98.9%	97.1%	96.5%	98.5%	96.2%		99.1%	95.3%	98.7%	94.5%	94.5%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		73.2%	90.3%	84.8%	91.2%	82.1%	81.0%	82.1%	60.0%	68.6%	77.4%	78.4%	76.9%		
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%	18.2%	59.0%	28.1%	35.3%	35.3%
Mixed Sex Accommodation breaches	Trustwide	0										0	0	0	0	0	0
Follow ups 6 weeks past to be seen date	Trustwide	6400		17118	16713	16323	16967	17651	17789	18231	18069	19797	20026	20496	21388	22516	22516
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.0%	4.0%	4.1%	4.1%	4.2%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.3%		4.1%
Appraisal Completeness	Trustwide	>90%		85.9%	86.6%	84.7%	81.3%	80.6%	79.7%	77.9%	79.2%	78.6%	76.1%	75.2%	71.9%	71.3%	71.3%
Mandatory Training Compliance	Trustwide	>85%		90.1%	90.1%	90.5%	89.5%	89.4%	89.0%	89.0%	88.8%	88.4%	88.6%	89.2%	89.5%	89.6%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.8%	11.0%	11.3%	11.0%	11.7%	11.3%	11.6%	11.5%	12.0%	12.6%	12.9%	13.4%	13.2%	

	ISU	Target	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	100.0%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		234	213	201	171	165	147	147	0	0	0	0	0	0	0
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET				110			189	0	0	264	0	0	0	0	365
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET				4.3%			5.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		0	608	629	631	564	546	604	590	628	644	623	645	671	671
Intermediate Care - No. urgent referrals	Trustwide	113		165	155	129	158	191	241	222	237	219	195	213	212	214	214
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		282	294	292	297	233	229	243	191	200	202			265	265
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide	94%		72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide	7%		7.5%	7.4%	7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%
% Adults with learning disabilities in settled accommodation	Trustwide	80%		93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		17.5	20.2	23.1	17.7	19.0	17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		499.8	510.8	487.3	498.1	511.5	449.6	422.7	411.9	376.9	487.3	476.5	570.8	576.2	576.2
Proportion of clients receiving direct payments	Trustwide	25%		20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%					85.9%	87.1%	87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	84.5%
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	58.0%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		62.7%	63.9%	64.4%	61.7%	59.4%	57.4%	57.0%	56.5%	55.6%	54.7%	54.7%	52.0%	50.4%	50.4%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		71.8%	77.9%	68.8%	67.8%	75.0%	73.3%	70.5%	57.0%	61.9%	49.1%	52.1%	59.5%	57.8%	57.8%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	41.3%	38.4%	36.8%	33.9%	33.9%
Dementia - Find - monthly report	Trustwide	>90%		96.7%	96.9%	97.4%	97.8%	97.2%	92.7%	94.4%	95.0%	87.3%	94.8%	89.7%	93.6%	91.7%	91.7%

	ISU	Target	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		2	5	2	5	8	2	1	2	6	6	3	7	2	2
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		67.7%	83.9%	83.0%	71.3%	54.6%	55.6%	50.5%	45.2%	44.3%	45.6%	48.1%	61.1%	59.6%	59.6%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		61.9%	54.1%	56.7%	91.0%	77.8%	92.4%	95.1%	79.8%	82.5%	38.6%	71.4%	81.0%	76.8%	76.8%
Cancer - 28 day faster diagnosis standard	Trustwide			75.6%	75.6%	76.0%	76.4%	77.4%	60.6%	58.8%	52.5%	52.8%	55.2%	73.1%	75.0%	76.9%	76.9%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		97.4%	96.7%	98.5%	97.5%	98.8%	99.4%	98.2%	96.7%	96.8%	94.8%	96.5%	97.4%	92.6%	92.6%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	97.3%	98.6%	98.6%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		98.5%	100.0%	97.0%	98.3%	96.4%	98.6%	98.4%	100.0%	100.0%	97.1%	98.3%	93.8%	94.7%	94.7%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		100.0%	96.7%	97.7%	100.0%	97.3%	100.0%	100.0%	97.1%	100.0%	96.4%	91.7%	82.9%	100.0%	100.0%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		75.0%	73.3%	85.7%	78.6%	92.3%	71.4%	87.5%	82.4%	77.8%	72.7%	85.7%	80.0%	70.4%	70.4%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			15	17	10	10	13	15	29	14	26	27	39	39	33	33
RTT 52 week wait incomplete pathway	Trustwide	0		1895	1596	1562	1648	1799	1943	2093	2169	2384	2584	2759	3199	3374	3374
RTT 78 week wait incomplete pathway	Trustwide	0		289	330	377	458	580	641	572	477	532	587	649	763	779	779
RTT 104 week wait incomplete pathway	Trustwide	0		6	13	23	42	71	100	116	126	147	182	213	245	192	192
On the day cancellations for elective operations	Trustwide	<0.8%		1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%	1.4%	0.9%		1.6%	1.6%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		6	11	3	10	17	5	3	30	12	6	8	11	12	12
Virtual outpatient appointments (non-face-to-face) - 1 month in arrears	Trustwide	25%		18.6%	19.2%	19.1%	20.0%	19.6%	20.3%	20.5%	21.1%	19.3%	20.7%	21.3%	18.8%		
Bed Occupancy	Acute	90.0%		89.0%	85.0%	87.0%	92.0%	95.0%	95.0%	93.0%	94.0%	93.0%	93.0%	93.0%	93.0%	94.0%	97.6%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target					45.4	57.8	55.6	61.7	66.1	87.8	101.1	80.2	70.4	70.3	
Number of patients >7 days LoS (daily average)	Trustwide			97.0	104.5	120.5	129.4	154.4	149.1	148.4	145.7	157.0	183.0	165.0	172.0	171.6	171.6
Number of extended stay patients >21 days (daily average)	Trustwide			15.2	21.3	25.0	26.3	41.5	43.9	43.6	39.9	48.0	64.0	60.6	50.0	45.6	45.6
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		90	128	380	421	266	219	285	959	952	889	727	1026	967	967
Ambulance handover delays > 60 minutes	Trustwide	0		19	26	173	165	120	72	125	617	616	559	438	757	680	680
A&E - patients recorded as >60min corridor care	Trustwide			0	0	0	0	0	0	0	0	0	0	0	0	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			14	46	246	438	534	491	753	788	712	806	364	701	656	656
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		2	3	32	157	188	69	130	139	162	131	123	202	155	155
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		1	3	2	4	7	2	1	1	3	5	1	5	2	2
Number of Clostridium Difficile cases - (Community)	Trustwide	0		1	2	0	1	1	0	0	1	3	1	2	2	0	0
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%	69.2%	75.2%	72.1%	71.1%	71.1%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		25.5%	33.1%	32.4%	34.2%	46.6%	46.4%	45.5%	50.7%	39.2%	36.7%	52.8%	48.6%	50.0%	50.0%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		68.5%	62.5%	66.5%	69.8%	69.0%	73.0%	67.7%	67.8%	69.1%	74.6%	67.7%	66.0%	69.5%	69.5%

	ISU	Target	13 month trend	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide				2623	2551	2438	1240	-367	-327	-401	-609	-845	-955	-2025	-187	
Agency - Variance to NHSI cap	Trustwide				-1.40%	-1.80%	-2.10%	-2.10%	-2.10%	-2.10%	-2.00%	-2.00%	-1.80%	-1.60%	-1.40%	-2.00%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide									-332	-593	-833	-659	-222	248	-1812	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide				2004	3206	4292	5275	9080	12336	16029	19492	20987	15148	15919	-57	
Distance from NHSI Control total (£'000's)	Trustwide				2690	2621	2638	1539	7	8	-13	37	153	88	-59	-5	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	0	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs 2019/20 BASELINE																	
Outpatients - New	Trustwide			-5.0%	-15.6%	0.8%	-20.1%	-14.2%	-4.5%	-19.0%	1.9%	-4.2%	-18.5%	-7.1%	22.4%	-16.3%	-16.3%
Outpatients - Follow ups	Trustwide			-7.6%	-12.8%	-0.8%	-13.0%	-10.1%	-5.8%	-19.0%	-2.7%	-6.9%	-22.2%	-15.2%	19.3%	-13.4%	-13.4%
Daycase	Trustwide			-8.9%	-20.5%	5.3%	-12.1%	-18.4%	-4.5%	-20.6%	-11.7%	-12.6%	-22.3%	-15.8%	17.0%	-17.7%	-17.7%
Inpatients	Trustwide			1.8%	-19.8%	-15.4%	-33.1%	-35.2%	-24.4%	-25.8%	-37.0%	-33.5%	-47.5%	-37.6%	-23.4%	-9.2%	-9.2%
Non elective	Trustwide			4.5%	3.8%	8.2%	4.1%	-5.1%	-0.8%	-7.9%	-9.6%	-14.9%	-12.2%	-10.3%	12.3%	-11.4%	-11.4%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			590	564	574	560	472	525	511	537	504	540	554	550	#N/A	
Intermediate Care GP Referrals	Trustwide			95	94	78	80	78	75	74	64	94	87	89	88	94	
Average length of Intermediate Care episode	Trustwide			11.73	12.59	12.42	16.36	13.46	14.57	12.19	12.20	14.10	13.60	15.60	15.60	#N/A	
Total Bed Days Used (Over 70s)	Trustwide			9713	8593	4035	9171	9240	9881	9871	12186	12896	13120	15944	9295	#N/A	
- Emergency Acute Hospital	Trustwide			5257	4953	5284	5179	5298	5238	6022	5610	6074	5935	7076	4011	#N/A	
- Community Hospital	Trustwide			3268	2981	3240	2973	2867	3318	3377	5610	6074	5935	5935	7076	#N/A	
- Intermediate Care	Trustwide			1188	659	795	1019	1075	1325	472	966	748	1250	1792	1273	#N/A	

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: May 2022 Mortality Safety Scorecard			Meeting date: 25 May 2022
Report appendix	List any supplementary information as shown below: Appendices 1 to 5		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	The report will go to the next: Mortality Surveillance Group meeting 09 June 2022 Quality Improvement Group Meeting 21 June 2022		
Purpose of the report and key issues for consideration/decision	The report is for monthly assurance to ensure learning from deaths.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive and note this report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	20
Risk Register		**Risk score**	

BAF Objective 3: To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement		**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Report title: Mortality Surveillance Score Card		Meeting date: 25 May 2022
Report sponsor	Medical Director	
Report author	Medical Director	

1.0 Introduction

The document 'National Guidance on Learning from Deaths' was first published by the NHS National Quality Board in March 2017 and provides a framework for NHS Trusts for identifying, reporting, investigating and learning from deaths in care. The Trust must have an executive director who is responsible for the learning from deaths agenda and a non-executive director who provides oversight of the progress. From April 2017, Trusts have been required to collect and publish, on a quarterly basis, specified information on deaths by submitting a paper to public Board.

For some patients, death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality provision of care resulting from multiple contributory factors. The purpose of reviews and investigations, where problems in care may have contributed to death, is to learn in order to improve and prevent recurrence.

Since April 2020, it has been a requirement that all in-patient deaths are scrutinised by a suitably trained Medical Examiner. Some deaths which cannot be readily identified by a doctor as due to natural causes are referred to HM Coroner for investigation instead. Medical Examiners are mandated to give bereaved relatives a chance to express any concerns and to refer to HM Coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

Some deaths require a case record review, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. This would particularly apply where bereaved families and carers or staff have raised concerns about the quality of care provision.

Lastly, some deaths require a formal investigation as guided by the Serious Incident Framework.

Data Sources

The indicators for this Scorecard have been collated from a variety of data sources using defined methodology. The report is designed to give a top-level view of our mortality data over time.

The report also includes mortality cases reviewed via the Trusts Morbidity and Mortality form based on the Royal College of Physicians Structured Judgement Frame Work (SJF) looking at any lapses in care as well as good practice.

Data sourced, includes data from the Trust, Department of Health (DH), and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group as well as local ISU governance groups.

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to err.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data which may be a signal of improvement or of a process starting to err.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		Data Source	Target	RAG
Appendix 1 • A. Hospital Standardised Mortality Rate (HSMR)	Mortality	Dr Foster latest benchmark Month	Below the 100 line with an aim for a yearly HSMR ≤90	Jan 2022 101.6 12-month average 107.3
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		103.2 (July 20 – June 21)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	3.12%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	CUSUM alerts greater than 1 in last 12 months	1
Appendix 4 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is 101.6 This is just above the expected level of 100 for our population for January 2022. The rolling 12-month position exceeded the expected range for the 12-months to January 2022 with a relative risk of 107.3 against an expected 100 benchmark. The rolling 12-month HSMR has been decreasing over the last 3 months. The summer months May, June, July, and August 2021 recording a higher than expected mortality rate.

The average palliative care coding rate has increased over the last 3 years and now is 4.87% which is close to the national rate of 4.79%. The Trust has improved recording of co-morbidity over the last 2 years and is now close to the national average. Deaths recorded as 'symptoms and signs' rather than a definitive diagnosis were higher at 12.2% compared to national averages 7.5% and this could increase the overall HSMR.

This report shows a continued increase in Medical Examiner activity. The Medical Examiner Office highlighted to the Trust that there have been increasing delays in death referrals and completion of the Medical Certificate of Cause of Death due to the current system pressures. The Medical Examiner Office is supporting additional operational processes to address this issue.

This month's report is identifying a number of increases in mortality and measured through both SHMI and HSMR for the period Q2 2021/22. The Performance Team, along with the Director of Patient Safety will be reviewing this position to provide a deeper analysis of factors contributing to this increase. Covid-19 is expected to be one of these factors as there has been an increase in the number of Covid-19 deaths reported in this period.
Inpatient deaths due to liver disease, alcohol related has seen a steady increase in relative risk volume since Aug 2021.

Weekend HSMR is statistically significantly higher than expected and weekday mortality is within the expected range. The weekend HSMR has shown a sustained decrease since August 2021.

Appendix 1 – Hospital Mortality

This metric looks at the two main national mortality tools and is therefore split into:

- 1A – Dr Foster's Hospital Standardised Mortality Rate (HSMR) and,
- 1B – Department of Health's Summary Hospital Mortality Index (SHMI)

1A The HSMR is based on the *Diagnosis all* Groups using the December 2020 monthly benchmark and analysed by Relative Risk - Trend / Month

Our HSMR aim is to reduce and sustain the HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated

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Chart 1 - HSMR by Month February 2021 to January 2022 (latest month available)
Chart one (as below) shows a longitudinal monthly view of HSMR.

The latest month's data, January 2022, has a relative risk of **101.6** (basket of 56 diagnostic groups) and is above the 100 average. The high HSMR recorded May to August has been subject to further review with no identified areas of concern.

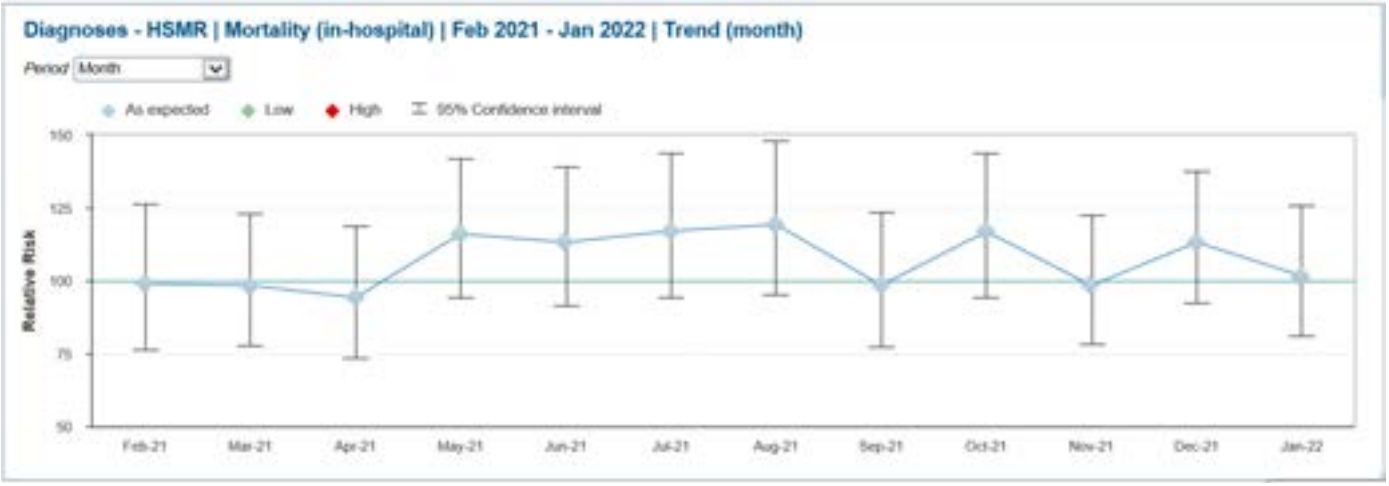


Chart 2 Peer Comparison, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total.

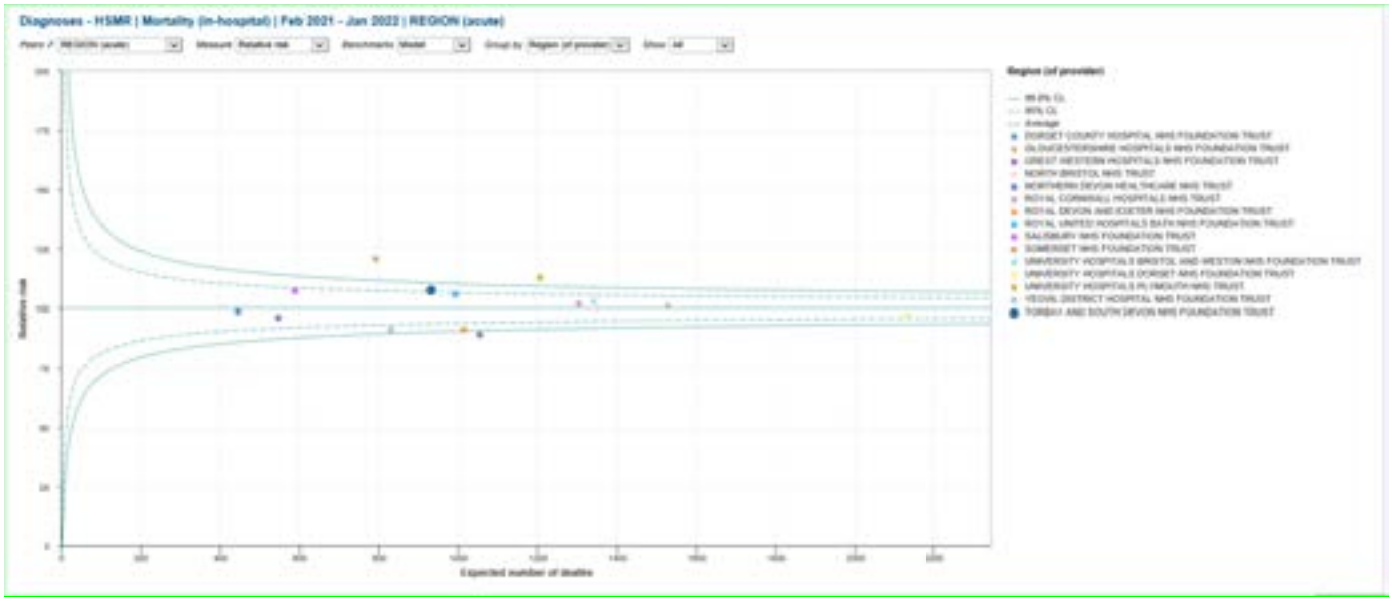


Chart 3 displays the above data as a peer comparison as a bar chart.
The 12-month average HSMR for Torbay and South Devon is flagging red as the lower confidence interval is just above the 100 benchmark. With the recent trend in lower HSMR we would expect this to improve over the coming months.

1B Summary Hospital Mortality Index (SHMI) Reporting Period July 2020 –June 2021

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon inpatient deaths **and** deaths up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective, therefore, please note *the following data is based on the* **December 2020 –November 2021** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarterly periods with all data points and confidence intervals within the expected range except two, which exceeds the average 100 relative risk mark. The first flag is Q1 2020/21 and relates to the first wave of Covid-19. The second flag for Q2 2021/22 with no significant cause identified.

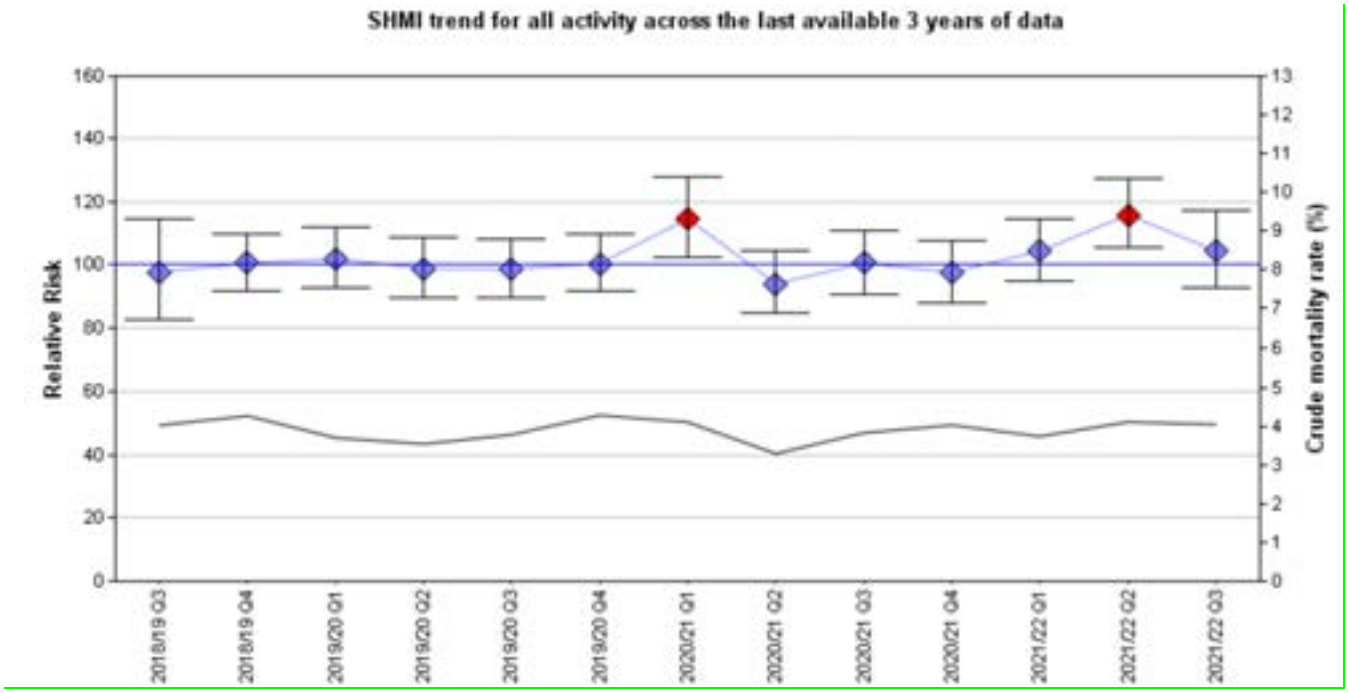


Chart 5 (as below) details SHMI all deaths, SHMI in hospital deaths, and HSMR comparison. The HSMR and SHMI demonstrate a consistent comparison. Confidence intervals are triggering a higher than expected range.

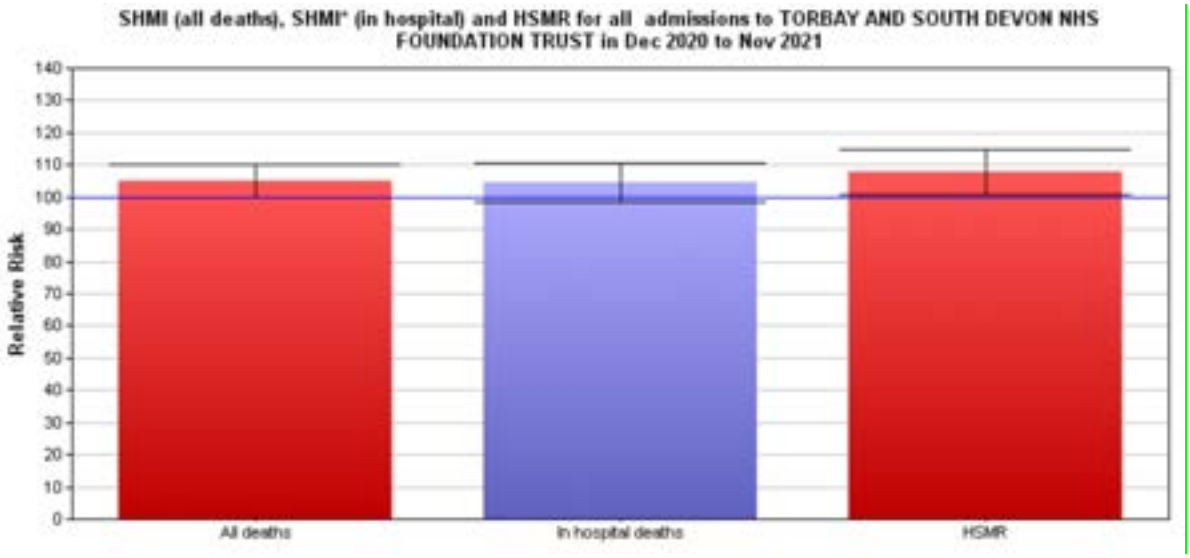
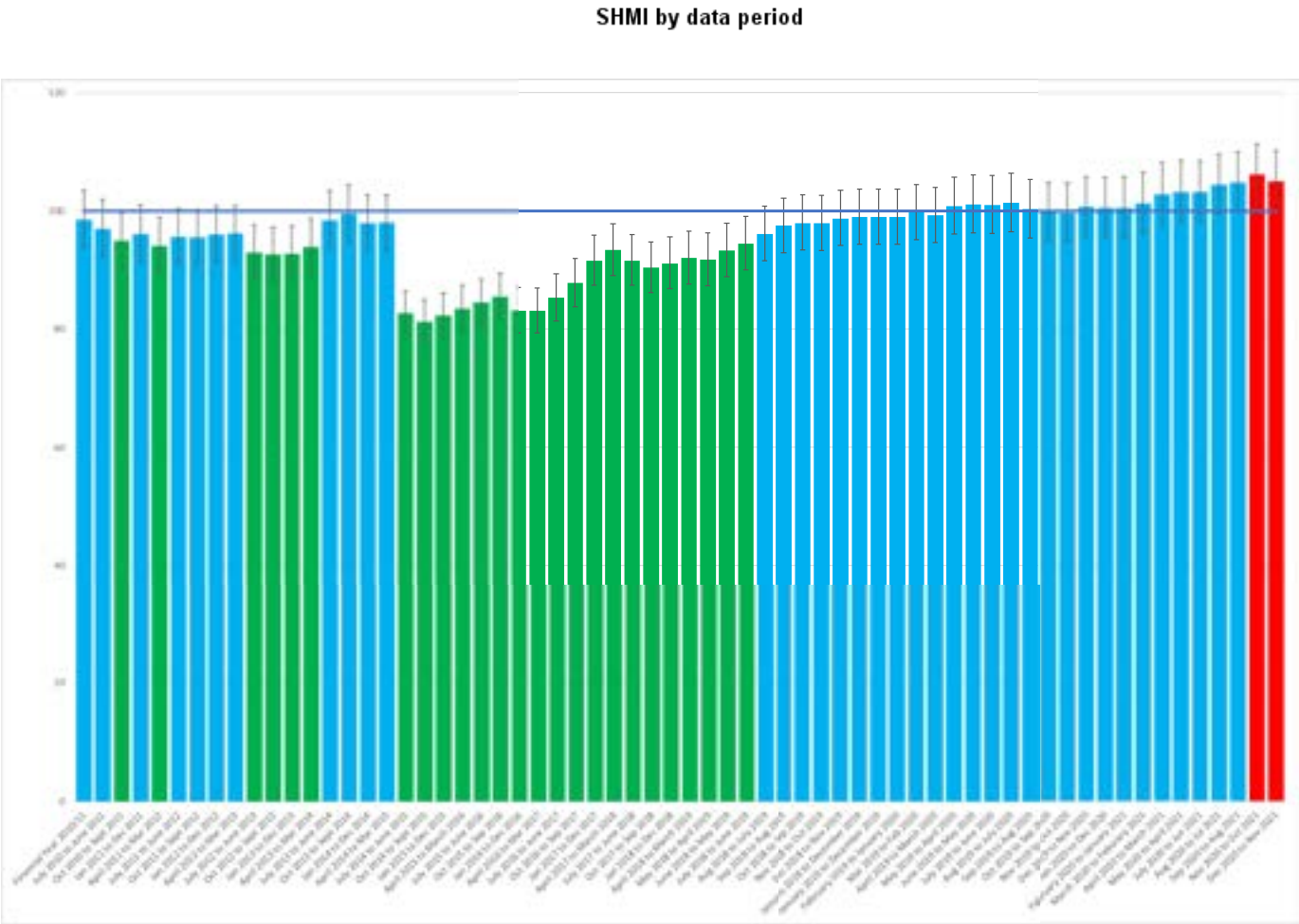


Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period (December 2020 –November 2021). The confidence intervals for the last two reported periods are just above 100 and will be subject to review.



Appendix 2 – Unadjusted Mortality Rate

This data looks at the number of deaths in-hospitals and expresses this unadjusted death rate as a percentage, as well as by number and location across time.

This percentage is defined as the monthly unadjusted or 'raw' mortality. It is calculated as follows:

Determine the numerator: the total number of in-hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

Determine the denominator: the current month's total number of in-hospital deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 7, below, highlights the Trust's in hospital unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart includes the Covid lockdown period and highlights a rise in deaths in March and April 2020. The mortality rise in March is partly explained by a reduction in activity due to Covid changes. The mortality rise in April is solely down to reduced activity. In April 2019 we had 3036 discharges (the denominator) and in April 2020 this, due to Covid, had reduced to 1773. Unadjusted mortality remains within normal limits for the Trust.

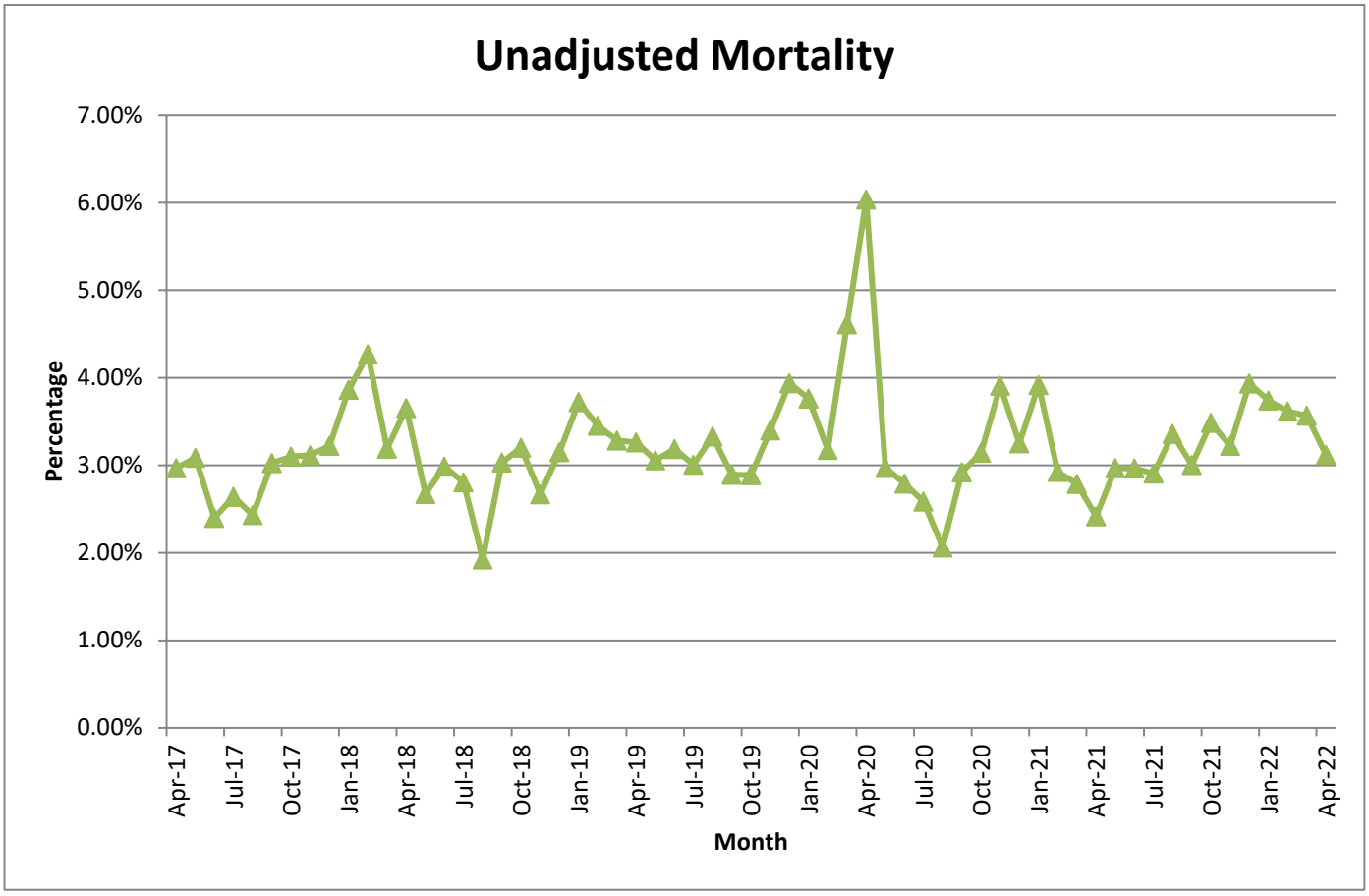
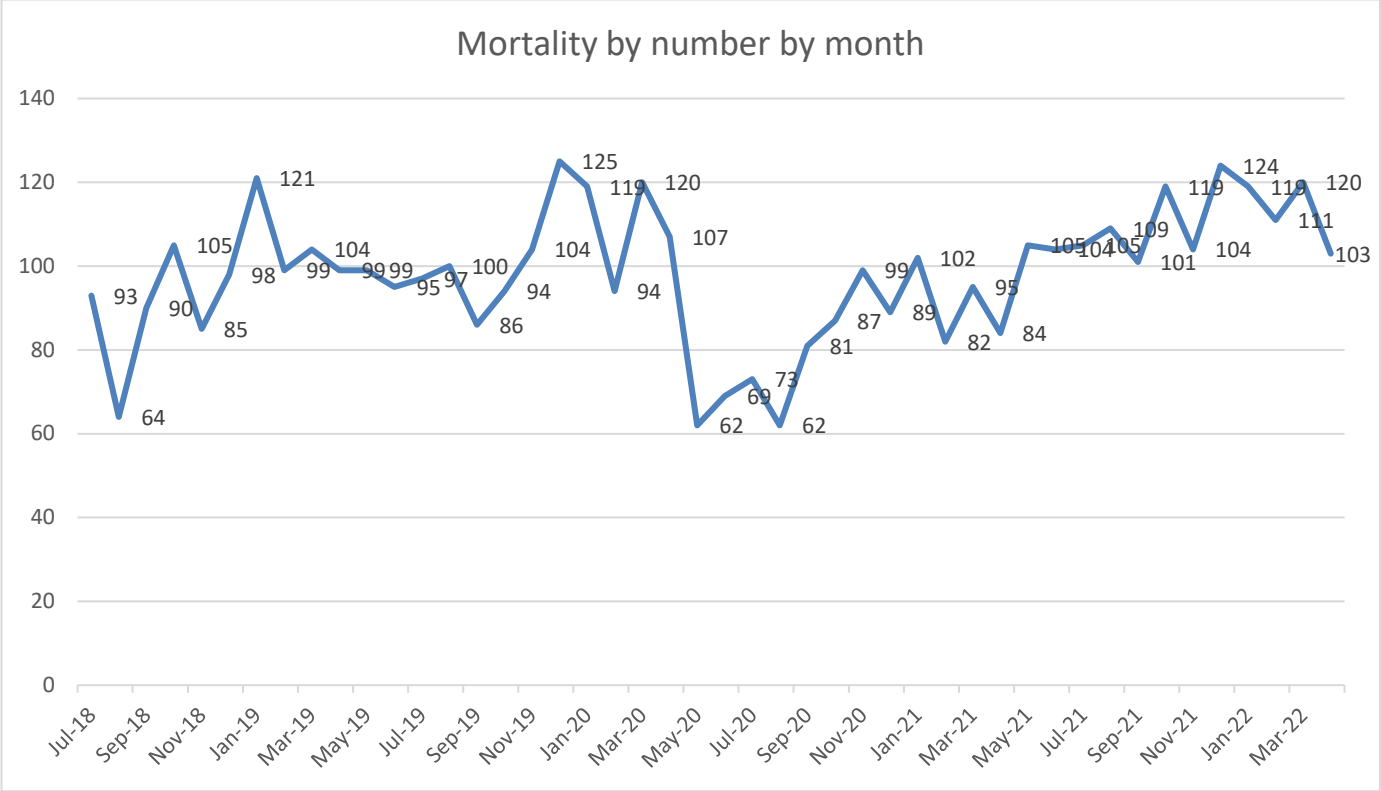


Chart 8 As below, indicates the monthly number of hospital deaths. This shows a rise in March and April 2020 partly due to Covid, before decreasing to comparatively low numbers during Summer 2020. As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has also increased. The pattern of increased deaths related to winter pressures appears to be re-emerging after a relatively low number of in-hospital deaths last winter.



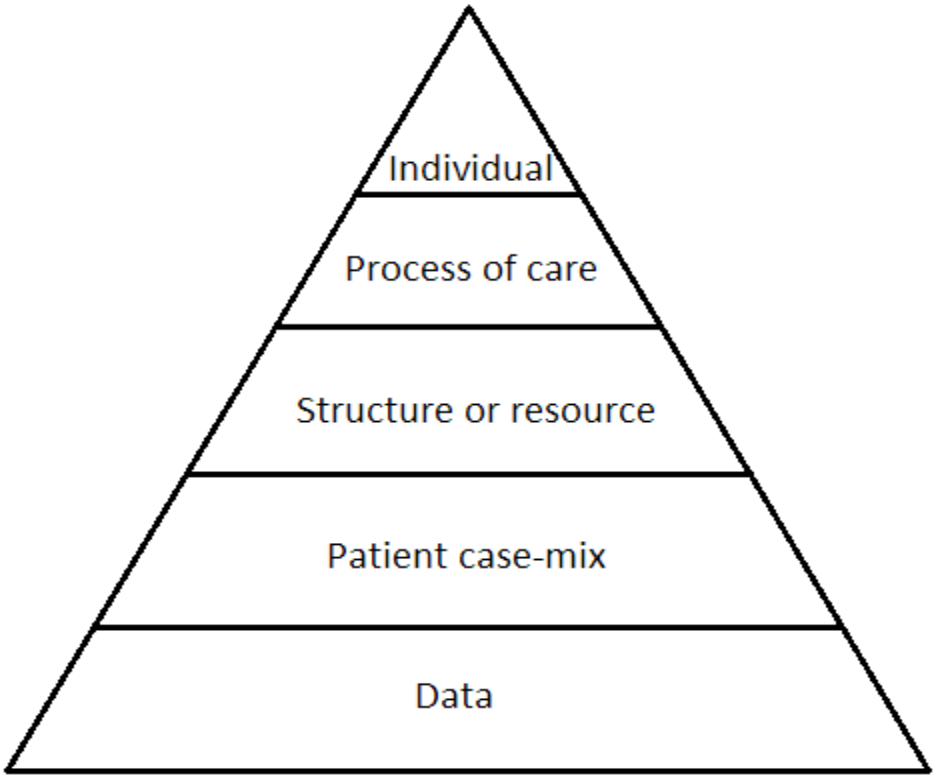
Appendix 3 – Mortality Analysis

Table 2 –highlights mortality by ward location by month and are within the expected norms for each ward area

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Torquay ISU																	
DELIVERY SUITE				1													
LCHDU																	
LOUISA CARY																	
MOTHER AND BABY																	
Paignton and Brixham ISU																	
BRIXHAM	2	6	4		5	1	1	1	1	2		1	1	2			
CARDIAC CATHETER SUITE							1								1	1	
DUNLOP	3	4		5	4	3	3	4	8	6	4	7	6	12	3	3	5
MIDGLEY	7	13	16	14	13	18	12	18	16	17	17	15	12	8	14	15	11
TORBAY CHEST PAIN UNIT											1						
TORBAY CORONARY CARE BEDS	3	1	2	1		2	2	3	4		3	2	3	3			2
TURNER	3	2	3	8		5	6	7	5	5	5	5	7	10	9	9	4
ELIZABETH	3	1	3	1	1	1											
WARRINGTON		2	1	1	2	2	2	2	3	3	4	3	1	1	3	1	1
Newton Abbot ISU																	
ACUTE MEDICAL RECEIVING UNIT																	
MEDICAL RECEIVING UNIT					1		3	4	1	3		2	6	4	3	7	
NEW MEDICAL RECEIVING UNIT																	
EAU3																	
EAU4	9	17	10	11	8	9	16	11	11	8	16	9	10	12	5	10	7
INTENSIVE CARE UNIT	12	2	5	4	5	10	16	7	11	3	8	13	12	11	5	8	13
TEMPORARY INTENSIVE CARE UNIT		1	1														
TEIGN WARD	2	2	1	2	1	3	2	2		4	2	1	2	2	1		1
TEMPLAR WARD	1		1	2	4		1	1			1		2	2	1		
Coastal ISU																	
AINSLIE	1	2	1	1	1			4	7	3		1	7	3	6	4	3
ALLERTON	8	2	3	8	4	6	4	3	7	2	8	7	7	8	7	15	8
CROMIE	7	13	6	2	2	7	2	5	5	5	5	3	6	3	8	5	6
DAWLISH		4	1	1			1	1		2			3		5	4	
ELLA ROWCROFT			3		1			2		1				3	1	1	2
FORREST		4	5	4				4	5	8	13	7	12	8	6	2	9
THEATRES		1							1						1	2	
Moor to Sea ISU																	
CHEETHAM HILL	11	12	10	11	10	11	7	9	11	12	10	13	6	10	11	10	7
DART				2	3	3		1		1	3		1	2			
GEORGE EARLE	9	8	4	8	10	8	13	8	9	9	10	6	12	5	8	9	9
SIMPSON	8	5	2	8	9	16	12	8	4	7	9	9	8	7	9	11	11
Wards used in Covid Surge response																	
JOAN WILLIAMS															2	2	1
MCCALLUM														3	2	1	3
Grand Total	**68**	**73**	**53**	**64**	**59**	**73**	**77**	**70**	**72**	**68**	**85**	**71**	**94**	**83**	**81**	**91**	**80**

Alerts by Clinical classification

An ‘alert’ is raised when the expected number of deaths is significantly exceeded by the actual number of deaths. The Trust adopts the ‘pyramid of investigation for special cause variation’ shown below to further investigate alerts.



1) 1st Step **Data**: has the data been coded accurately, have all the comorbidities been recorded and coded, does the coding reflect what actually happened to the patient?
2) 2nd Step **Patient case-mix**: Has something happened locally to affect the case mix? For example, patients admitted for end of life care and if so has a palliative care coding been recorded?
3) 3rd Step **Structure or Resource**: were there any changes to the structure and availability of resources e.g. availability of beds, equipment and staff
4) 4th Step **Process of car**e: have new treatment guidelines been introduced, have appropriate care pathways been consistently followed, have there been changes to admission or discharge practices?
5) 5th Step: **Individual:** An individual is rarely the cause of an alert. A consultant name may be recorded against the primary diagnosis but many individuals and teams are involved in providing care. Have there been any changes to staff or teams during the investigation

Table 3 – Dr Foster Alerts by clinical classification

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	1 10	74305	1268	1263.2	1.7	100.4	
HSMR (56 diagnosis groups)	2	29830	999	931.3	3.3	107.3	
Abdominal hernia		599	8	3.4	1.3	237.6	
Abdominal pain	1	2360	4	2.4	0.2	163.8	
Intestinal infection	1	693	13	8.3	1.9	156.9	
Intrauterine hypoxia and birth asphyxia	1	7	1	0.0	14.3	3283.8	
Liver disease, alcohol-related		199	22	13.6	11.1	161.9	
Noninfectious gastroenteritis	1	126	3	1.1	2.4	267.4	
Open wounds of extremities	1	179	4	0.9	2.2	438.5	
Open wounds of head, neck, and trunk	1	198	6	2.9	3.0	208.4	
Other connective tissue disease	1	725	10	3.9	1.4	259.2	
Peritonitis and intestinal abscess	1	28	5	2.1	17.9	241.0	
Respiratory failure, insufficiency, arrest (adult)	1	31	10	6.7	32.3	150.2	
Syncope	1	313	6	1.7	1.9	348.7	

Alerts with observed deaths greater than 10 are currently under investigation:

i) Deaths due to Intestinal infection are higher than expected (13 observed vs 8.3 expected.) Already reviewed, this does not appear to be due to coding issues and has been discussed at Mortality Surveillance review.

ii) Deaths due to liver disease, alcohol-related are higher than expected (22 observed vs 13.6 expected). This is a new alert and will be reviewed.

iii) Deaths due to other connective tissue disease are higher than expected (10 observed vs 3.9 expected). Preliminary analysis of the data suggests the majority of the deaths due to 'other connective tissue disease' occur in the frail, elderly cohort and 8 out of the 14 deaths are coded as having 'a tendency to fall'. Next steps in analysis will be a review of coding in these patients.

Chart 9 The SHMI clinical classification software (CCS), clusters patient diagnoses and procedures into a number of manageable and meaningful groups. This chart shows deaths occurring in hospital and all deaths (i.e. in-hospital deaths and deaths occurring within 30 days after discharge) by clinical cluster. This month's position highlights alerts for mortality due to acute and unspecified renal failure, and congestive heart disease(non-hypertensive) in deaths occurring in hospital and up to 30 days after discharge. Septicaemia (except in labour) is alerting for in-hospital deaths but not alerting for deaths up to 30-days post discharge. Further analysis will be discussed with the Director of Patient Safety.

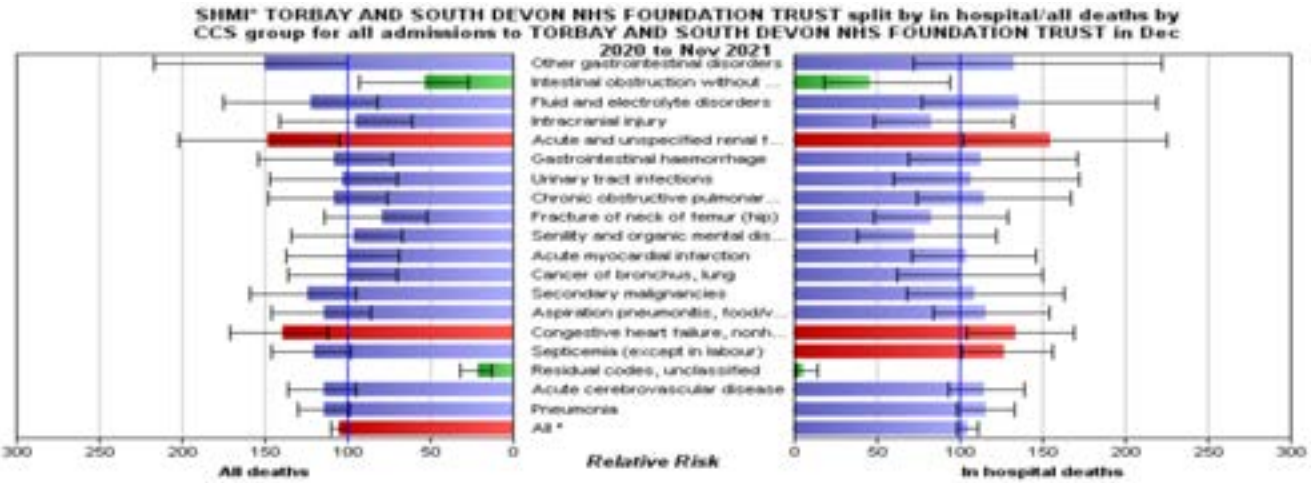
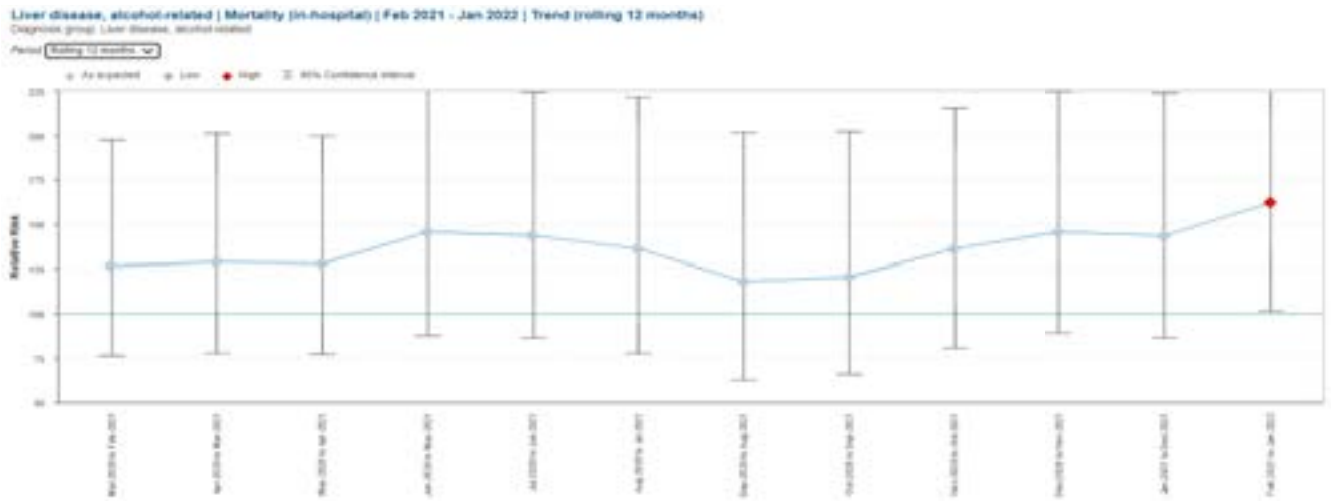


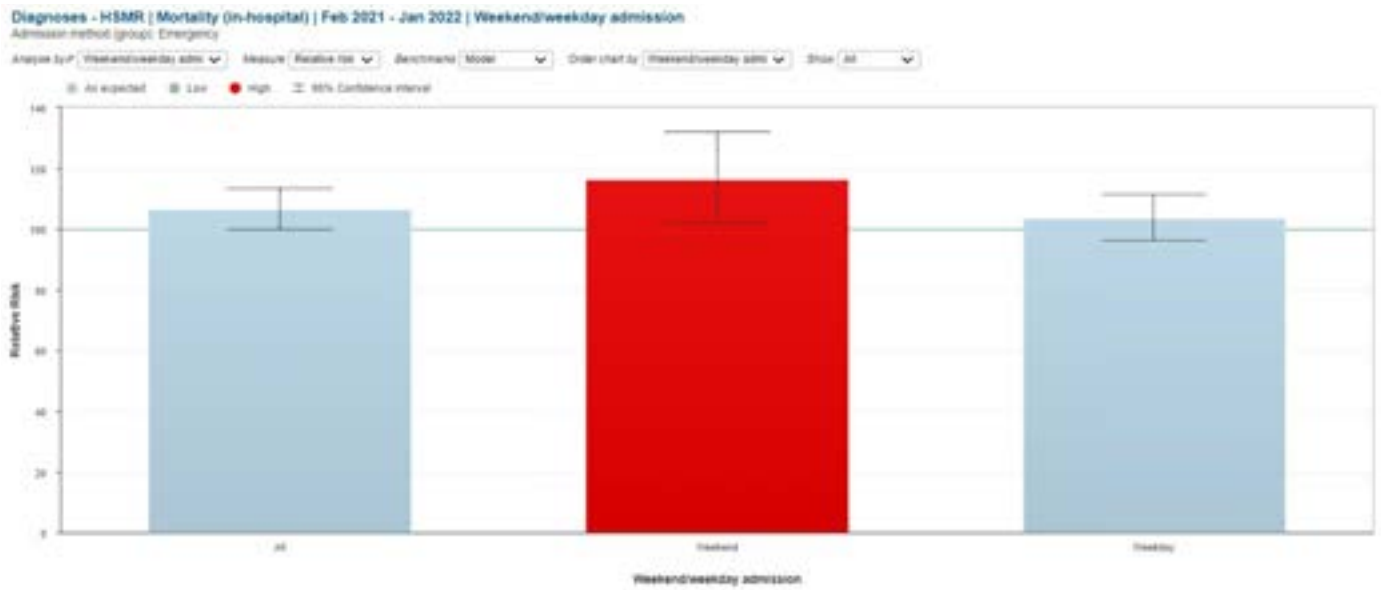
Chart 10 – Liver disease, alcohol related in hospital mortality



- Liver disease, alcohol related has seen a steady increase in relative risk volume since Aug 2021.
- Over 50% of the observed deaths are recorded under the ICD10 code Alcoholic hepatic failure.
- Gastroenterology is recorded as the main speciality on admission.

Chart 11 – Emergency Weekday / Weekend HSMR

Weekend HSMR is statistically significantly higher than expected and weekday is within the expected range. The weekend HSMR has shown a sustained decrease since August 2021.



An increased mortality in patients admitted at a weekend compared to a weekday is seen in a number of NHS Trusts. Possible explanations include a relative reduction in overall admissions at weekends (the denominator) but continued admission of seriously ill patients who die (the numerator). Recent discussion at South West Medical Directors and Chief Nurses meeting suggested that the reduced availability of community health resources at weekends led to later presentation of emergency patients compared to weekdays and was a significant factor explaining the increased mortality rate at weekends. The difference in healthcare resources in the acute hospital sector at weekends is also suggested as a possible cause. The Patient Safety team plan to investigate the 'weekend effect' locally and will report on the findings.

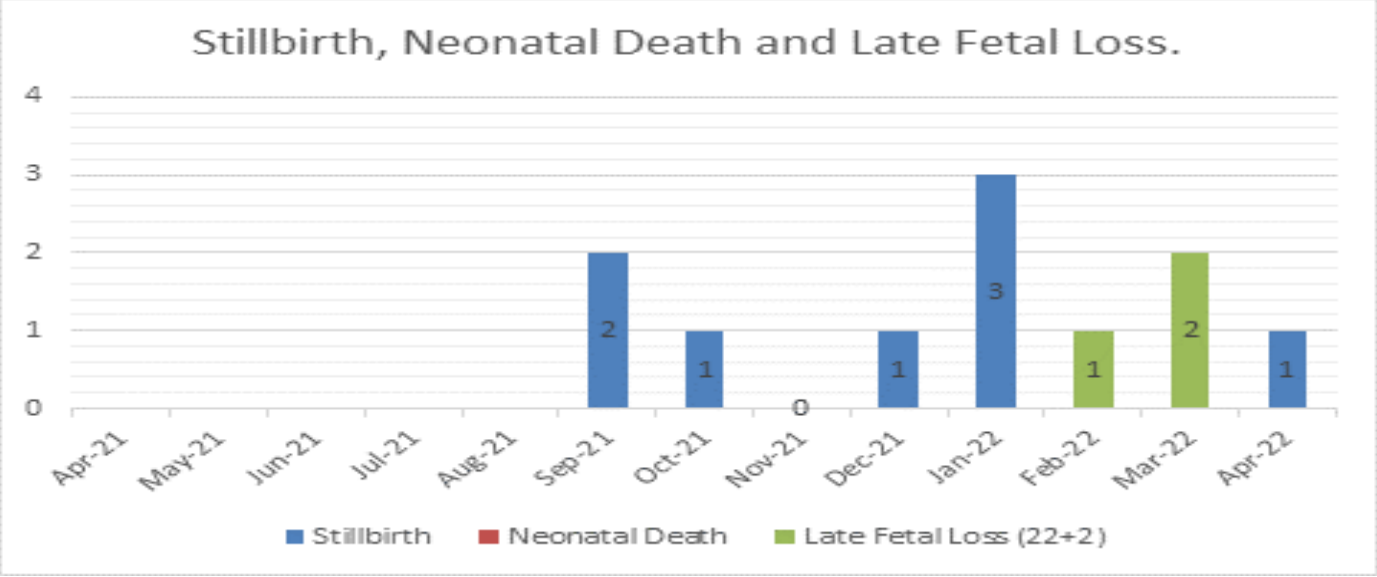
Number of deaths of a patient with a Learning disability

Patients with learning disabilities currently have a life expectancy at least 15-20 years shorter than other people. The Learning Disabilities Mortality Review (LeDeR) programme requires an independent case review following the deaths of people with Learning Disabilities. All deaths involving patients with a learning disability are reviewed through the LeDeR process. This feeds back into the Trust any learning. Currently up to date data from the LeDeR process is not available but the central patient safety team and CCG are working together to provide timely feedback. Further updates are awaited.

Number of Neonatal, Perinatal, and Maternal Deaths

A stillbirth is when a baby born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.
During February and March, we had three pregnancies which were Late fetal losses, these are babies that have died prior to 24 weeks gestation. In line with the national requirement to review all babies between 22+0 and 23+6 weeks gestation this data, along with a description of the cases, was discussed at our multidisciplinary clinical effectiveness meeting in April 2022. There did not appear to be any themes on the initial case reviews.
There was one stillbirth in April – This was a Mother who had known risk factors and delivered her stillborn Baby antenatally at 27+5 weeks.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Number of child deaths

Over the last 20 years the UK has gone from having one of the lowest mortality rates for 0-14-year olds to one of the highest. There is a strong association between deprivation and mortality; for example, infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups.

There have been 2 deaths of children treated at the Trust since March:

1. 3-year-old child assessed at Torbay and transferred to Bristol Children's Hospital. Cause of death: 1. Severe inflammatory/auto-immune brain damage 2. Secondary

hemophagocytic lymphohistiocytosis, following infective trigger 3. Pneumococcal bacteraemia 4. severe acute respiratory syndrome coronavirus 2 (SARS CoV 2). Had been reviewed in Torbay ED in the previous 48hrs

2. 11month child assessed at Torbay and died in Bristol Children's Hospital Paediatric ICU Cause of death: 1 Global hypoxic brain injury 2. Pneumococcal meningitis

Number of deaths in which complaints were formally raised by the family

During March and April there have been 4 formal complaints relating to end of life care.
3 of these are currently active and relate of care or medical treatment. There is 1 closed case related to treatment

In addition, there have been 10 concerns and 3 compliments relating to care and / or medical treatment at End of Life.

Medical Examiners

The Medical Examiners are now functioning at full complement.
Within the Medical Examiners independent role, the office has highlighted an issue with increasing delays in the receipt of death referrals and breaches to the completion of the Medical Certificate of Cause of Death (MCCD) within the required 5-day period for registration. This is attributed to staffing shortages and the removal of the COVID death certification amendments which allowed any doctor to complete the MCCD. Whilst this is being actively managed on a daily basis vis escalation via Control Room and senior medical leadership team, it continues to contribute to the Trusts mortuary capacity issues and is resulting in increased informal concerns and complaints being raised by the bereaved.

During March and April 2022, a number of patient deaths were passed without scrutiny to reduce the distress to the bereaved due to the delays in issuing the MCCD's as demonstrated in chart 13. It is anticipated that scrutiny will become statutory within a few months.

Chart 13 – Medical Examiners Performance Summary

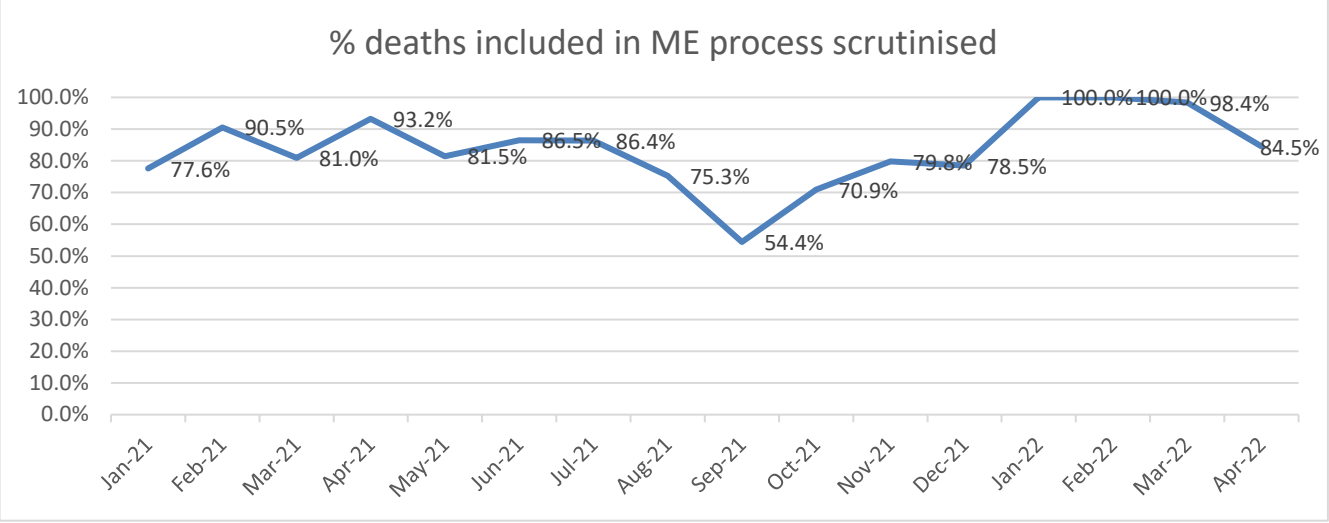
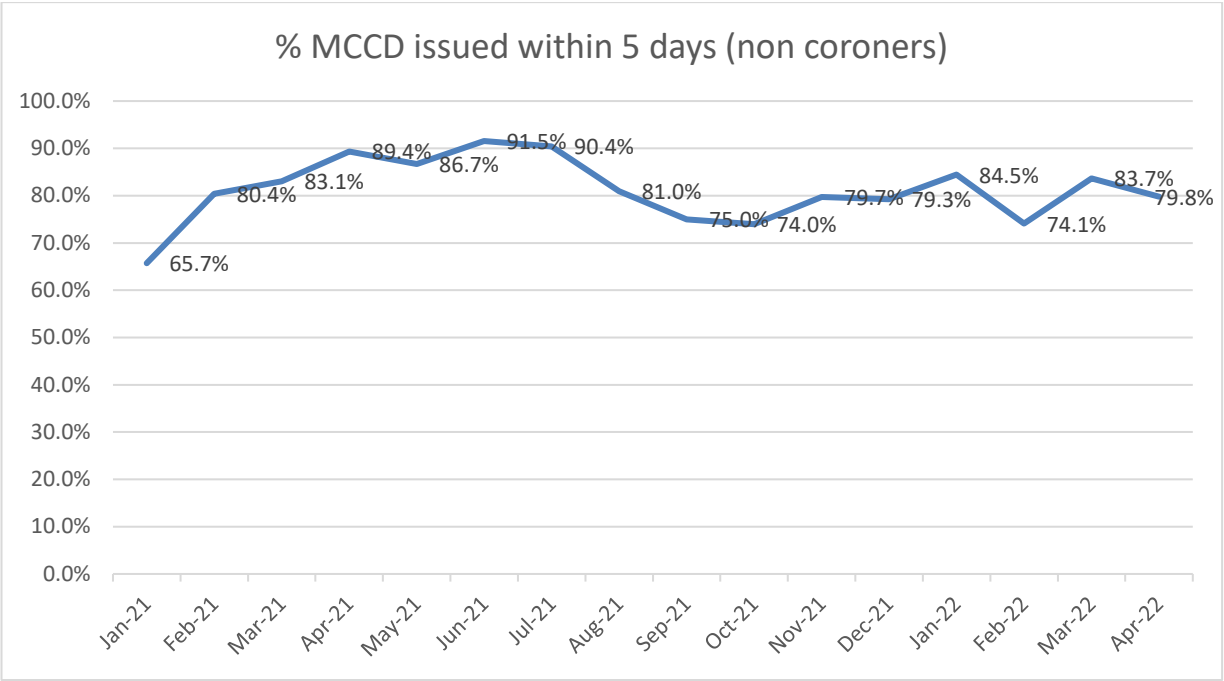


Chart 14– MCCD completion within 5 days



Cardiac Arrest Audit - Requested

Full year audit data for 2020 / 2021 indicates nothing out with the normal expected range for the Trust. There were a total number of 55 cardiac arrests during this year. This rate is on the national average and maintains the downwards trend since 2018. The mean age was 71 (down from 79yrs in 2018) and was 60% male.
The survival to discharge rate was 20% which is an increase from 17% in 2017 and is on the national average. The Trust is slightly above average for shockable arrests and slightly below for Pulseless Electrical Activity (PEA) arrests.

Numbers of arrest had dropped but are now heading back to pre-pandemic levels.

Learning from Inquests

During January and February 2022 were three inquests with two attended by the Trust.

The Trust has no outstanding Regulation 28 reports.

Trust learning: Serious Adverse Event Group March and April 2022

Key Issues	Learning and actions taken
Treatment / Diagnostic learning The SAE group discussed investigations into two deaths in April 2022	
1. Sudden unexpected death of an eleven-week-old baby	Possible bronchiolitis. Initial investigation showed no lapses in care. Case presentation by paediatric team due June 2022
2. Emergency presentation after punch to head. Unclear if vomited, Glasgow Coma Scale (GCS) 15/15, normal observations so discharged. Represented to ED a week later with reduced level of consciousness, and vomiting. GCS =11. CT acute on chronic sub-dural haematoma with obstructed hydrocephalus. Transfer neurosurgery Derriford and died there. Coroner's inquest awaited.	Case presentation by ED team due June 2022. Need for contemporaneous clinical record keeping. Clinical indications for CT examination in head injury reviewed by ED department.

Glossary of Terms

HSMR (Hospital Standardised Mortality Rate) - the case-mix adjusted mortality rate relative to the national average.

- **Relative Risk (RR)** - The ratio of the observed number of negative outcomes to the expected number of negative outcomes. The benchmark figure (usually the England average) is always 100; values greater than 100 represent performance worse than the benchmark, and values less than 100 represent performance better than the benchmark. This ratio should always be interpreted in the light of the accompanying confidence limits. All HSMR analyses use 95 % confidence limits.

CUSUM Alerts - CUSUM is short for 'cumulative sum'. The charts show the cumulative sum of the differences between expected outcomes and actual outcomes over a series of patients. The total difference is recalculated for each new patient and plotted on a chart cumulatively (i.e. where one patient's difference ends the next one starts). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold. They indicate a series of events that have occurred that are sufficiently divergent from expectations as to suggest a systematic problem. Alerts are triggered when the CUSUM statistic passes through a set threshold. This is shown graphically on the charts by a black cross on the threshold. Once an alert has been triggered the chart is re-set to the mid-way point. This will mean that another run of negative outcomes compared with expected outcomes will trigger an alert in a shorter timescale. The threshold value determines when the CUSUM graph is deemed to be out-of-control (i.e. higher or lower than the benchmark). At this point an Alert is raised and the CUSUM value is reset to half the threshold. The value selected affects the probability that an Alert is a False alarm and the probability that a real alarm is successfully detected. A high threshold is less likely to trigger false alarms but is more likely to miss a genuine out-of-control condition, and vice versa for a low threshold. For example, if chosen "Maximum (99.9%)" the system will select the highest threshold which corresponds to a False Alarm Rate (FAR) that is less than or equal to 0.1% given the annual volume and expected outcome rate of the analysis. With that threshold, only 0.1% of hospitals with in-control outcome rates (i.e. equal to the benchmark) will alert

Charlson Index of Comorbidities
Co-morbidity is assigned to the spell from assessing the secondary diagnoses codes, that are coded in the episode of care used to derive the primary diagnosis. In majority of cases this will be the first episode of care (on admission to hospital), however, where the primary diagnoses in the first episode of care is an R code, the system will look to the second episode of care to identify a clearer diagnosis, should one be available. In that case the secondary diagnoses of the second episode will be used. The Charlson Index of comorbidities is used both for the HSMR and the SHMI.

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: CQC Annual Assurance Report			Meeting date: 25th May 2022
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice, South Devon Quality and Compliance Manager		
Report provenance	Reports on all aspects have been provided to Quality Improvement Group (QIG), Quality Assurance Committee (QAC) and the Trust Board, through the year.		
Purpose of the report and key issues for consideration/decision	To provide an annual update for assurance, for the period April 2021 to March 2022, on: • Compliance with CQC standards and response to previous CQC inspections • The Trust's current registration status • The CQC's monitoring activity of the Trust • Preparation for future inspections and monitoring activity.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to receive and note: • The Statement of Purpose • Changes to CQC Regulatory approach • Update on Trust actions against findings from recent inspections • Preparation for future monitoring		

Summary of key elements

Strategic objectives supported by this report			
Safe, quality care and best experience	x	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	x
Is this on the Trust's Board Assurance Framework and/or Risk Register			
Board Assurance Framework	x	**Risk score**	20
Risk Register	x	**Risk score**	12

	BAF Objective 4: To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19
External standards affected by this report and associated risks	

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
NHS England	**x**	**National policy/guidance**	**x**

Report title: CQC Annual Assurance Report		**Meeting date:** 25th May 2022
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice, South Devon CQC Compliance Manager	

1. Introduction

This report provides the 2021/22 annual update to the Trust Board on the following:

- Trust's registration status (Section 2)
- Statement of Purpose updates (Section 3)
- Update on future changes to CQC's regulatory approach (Section 4)
- CQC formal Trust inspections and ratings 2021/22 (Section 5)
- CQC's ongoing monitoring of the Trust (Section 6)
- Preparation for future monitoring/inspection visits (Section 7)

The CQC became fully operational in 2009 as the independent regulator of health and social care in England. Since 2010, all providers of health and social care in England have been legally required to register with the CQC.

From 1 April 2015, new Health and Social Care Act Regulations came into force, setting out the Fundamental Standards of care that all providers must meet, and below, which the care they provide must not fall. The Key Lines of Enquiry (KLoE) and all CQC activity has its bedrock in these standards.

2. Trust's Registration Status

Torbay and South Devon NHS Foundation Trust (T&SDFT) is currently registered with the CQC to provide the following regulated activities, with no conditions or restrictions on its registration:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Personal care
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

3. Trusts Statement of Purpose Updates

The Statement of Purpose is a document legally required by Trusts that includes a standard set of information about the services we provide. TSDFT's Statement of Purpose was last updated in 2nd February 2022 to reflect changes brought about due to COVID, such as service location moves, temporary stops and restarts. The document had also been updated earlier in the year, as the Trust finessed its Covid response plans.

This document will be reviewed again, in May 2022, as the Trusts normalises more services as we move to *Living with Covid-19* as part of the Governments new phase of managing Covid nationally.

4. Update on Future Changes to the CQC's Regulatory Approach

In May 2021 the CQC released its five-year strategy, following extensive public consultation.

The CQC launched the new strategy with the aim of making a positive impact on patient care while regulating providers in a much more targeted and risk-based way. The refocus also reflects the dramatic way health and social care have changed over the past 10 years and the CQC wanted its focus to be people and community centric. To this end they have set out 4 themes, two core ambitions and 12 outcomes.

Themes:

1. People and communities – CQC's regulation will aim to be driven by people's needs and experiences
2. Smarter regulation – the new strategy will focus on deploying a more dynamic and flexible approach by providing up-to-date and high-quality information and ratings
3. Safety through learning – CQC will have a complete focus on safety by requiring a culture that enables people to voice concerns, allowing for shared learning and improvement opportunities
4. Accelerating improvement – lastly, the CQC will encourage health and care services as well as local systems to access support to help improve quality of care.

Core ambitions:

1. Assessing local systems: Providing independent assurance to the public of the quality of care in their area
2. Tackling inequalities in health and care: Pushing for equality of access, experiences and outcomes from health and social care services

CQC outcomes:

People and communities' outcomes

1. Our activity is driven by people's experiences of care.

2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation outcomes

1. We are an effective, proportionate, targeted, and dynamic regulator.
2. We provide an up-to-date and accurate picture of quality.
3. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.

Safety through learning outcomes

1. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
2. People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement outcomes

1. We have accelerated improvements in the quality of care.
2. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions: Assessing health and social care systems, and tackling inequalities in health and social care

1. We have contributed to an improvement in people receiving joined-up care.
2. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

What this means for the Trust

The Hospital ratings system will remain, however being rated by physical inspections according to a set time frame is coming to an end and a continuous assessment based on risk will be deployed. Any site-based inspections will likely be reserved for those care providers which cause the CQC's internal systems to alert them to an unacceptable increase in risk, based on the information and data they have gathered.

The complicated and multiple 'key lines of enquiry' will be replaced by one simpler system of questions rooted in what people expect of services. These questions focus on statements which the CQC considers to be more relatable both to providers and the public at large than is the case presently. Currently the thought is these will be called Quality Statements.

The five key questions the CQC apply to inspect will remain and any contact/inspection/assessment will still be based on the following: are services safe, effective, caring, responsive and well led? The 12 fundamental standards, (person

centred care, dignity & respect, consent, safety, safeguarding from abuse, food and hydration, safe premises, complaints, good governance, safe staffing, fit & proper staff and duty of candour) also remain unchanged. These are the basis of what and how we deliver care and the focus of the Trust in terms of CQC preparedness.

The Provider Information Request (PIR) is no longer required. This was a substantial and broad data gathering exercise that took place a number of weeks before an inspection. In the new strategy the CQC will look to be more specific in respect of the data & evidence required to demonstrate that a service is good or outstanding. There will also be a scoring system for each piece of evidence that will be required to be provided. This will allow more transparency of the CQCs inspection process and aid Trusts in their preparations.

The CQC will also continue to use its monthly Direct Monitoring Approach (DMA) in assessing core services via their monthly meetings. Here, under the 5 key questions (as mentioned earlier) the Trust provides information demonstrating compliance which is discussed via the pre-arranged Teams meeting with the CQC inspectors.

Timescales for revised approach

Their strategy is not set in stone and is likely to be refined further as the CQC develop the tools and documents they need to explain their new regulatory approach.

To date, we are waiting for further information to be released by the CQC but in the interim, the Trust must continue its focus on delivering the fundamental care standards and in maintaining or improving the quality of the care it gives in conjunction with its community and partners.

5. CQC Formal Inspection Visits and Trust Ratings

With effect from February 2022, the CQC have resumed normal inspection activity, paused due to COVID in 2020. This includes a return to inspect and rate NHS trusts that are rated Inadequate (I) or Requires Improvement (RI). They have continued necessary inspections, based on risk during Covid and this methodology continues. Additionally, the CQC will continue with their programme to inspect in-line with risk for emergency departments and the findings from the Ockenden Report will form a natural part of their Maternity activity.

During the period April 2021 to March 2022, TSDFT has received one formal CQC inspection.

The CQC carried out a short announced Focused Inspection on 1 December 2021 where they visited the Emergency Assessment Unit 4 (EAU4), Forrest Ward (the trust's escalation ward at the time of the inspection) and for comparison, George Earle Ward. The CQC carried out this inspection because a number of concerns had been raised with them relating to: staff shortages; concerns that patients were not receiving enough nutrition and hydration on Forrest Ward; and, concerns that staff were not completing observations on patients in a timely manner on both wards.

In March 2021, the CQC published the report from the above announced inspection. In response, and prior to its release, the Trust had developed a comprehensive improvement plan which became and still remains a priority for the organisation.

The CQC report recorded 3 Must Do improvement actions and these are:

- Ensure risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h)).
- Ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)).
- Ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).

As well as 3 Should Do improvements:

- Improve governance processes to have clear identification of patient risk.
- Improve processes to identify the acuity of patients on EAU4 and adjust staffing levels appropriately.
- Review the Core Training Policy which includes statutory and mandatory training.

The following table sets out our approach to improvement against these requirements:

<table>
<tr><th>Improvement Requirement</th><th>Action</th><th>Current Position</th></tr>
<tr><td colspan="3">Must Do Improvement Actions</td></tr>
<tr><td>Ensure patient risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h)).</td><td>• A comprehensive action plan was created in December 2021
• The overarching risk assessment framework has been revised and amended
• Daily clinical audits
• Monthly Matron audits
• Monthly reports at Quality Improvement Group and IGG</td><td><table><tr><th>Risk assessment</th><th>Compliance</th></tr><tr><td>Falls</td><td>83.1%</td></tr><tr><td>Capacity</td><td>90.9%.</td></tr><tr><td>Pressure ulcers</td><td>83.4%.</td></tr><tr><td>End of Life (TEP)</td><td>86.7%</td></tr></table></td></tr>
<tr><td>Ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)).</td><td>All staff follow the Six Steps to Patient Safety that the Trust has created:</td><td>83.3%
(Taken from monthly Safety Assessment audit)</td></tr>
<tr><td>Ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).</td><td>• Daily electronic auditing of the care booklet continues
• All patients are discussed at the Ward Safety Brief
• The Audits results are discussed with the ward manager matron meetings and to the weekly Matron ADNPP meetings too
• Standing agenda item on all ISU IGG's and ISU leads aware.
• Reported at QIG and exception reporting to QAC
• GGI have been commissioned by the organisation to review and strengthen clinical governance processes</td><td>There is more work to do to strengthen our governance process and emend this as a priority. This includes;
➢ Peer to peer review of evidence of audits
➢ Work with GGI to strengthen governance processes in ISU
➢ In the interim a "Good Governance Guide" is being developed for clinical leaders</td></tr>
<tr><td colspan="3">Should Do Improvement Actions</td></tr>
<tr><td>Improve governance processes to have clear identification of patient risk.</td><td>• The auditing process and focus on the patient assessment booklet Trustwide has provided a clear way to assess and identify the risks patients may have as well as ensuring the correct action are taken to meet their needs</td><td>The auditing process and results are discussed at the relevant board rounds, and meetings to ensure the clear identification of patient risk is paramount</td></tr>
<tr><td>Improve processes to identify the acuity of patients on EAU4 and adjust staffing levels appropriately.</td><td>• There is a process in place to review staffing and patient acuity data electronically at the twice daily Safe Staffing meeting
• Monthly reporting to the Nursing & Midwifery Workforce Council to ensure oversight and scrutiny.</td><td>More work is needed to ensure improvement in compliance of recording patient data. This is being led by the ISU ADNPP with support from the Safer Staffing Lead.
55% of days in the month patient acuity scores were completed in March
36% of days in the month acuity scores were completed in March</td></tr>
<tr><td>Review the Core Training Policy which includes statutory and mandatory training</td><td>• A new assurance framework has been completed and approved at PEGG</td><td>Policy review is in place with an expected close date of Sept 2022</td></tr>
</table>

The Table below lists the Trusts Core Services and their CQC activity in 2021/22, as well as their rating and when that was attained. Please note the Trust has an overall CQC rating of Good

Table 1. Core Services Ratings by CQC as of Year End 2021/22 and areas visited

CQC designation	Core Service	Current rating (date rated)	April 2021 to March 2022 CQC activity (not rated)
Acute (Torbay Hospital)	Urgent and Emergency	Requires improvement (2020)	
	Medical care (inc older people's care)	Requires improvement (2020)	Dec 2021 on-site Focused Inspection on EAU4 and Forrest ward – 3 Must Do actions DMA – Oct 2021
	Surgical Care	Requires improvement (2020)	DMA – Aug 2021
	Critical care	Good (2016)	DMA Canx by CQC due to Covid - Jan 22
	Maternity Care	Requires improvement (2020)	DMA - April 2022
	Gynaecology	N/A	DMA Canx by CQC due to Covid - Jan 22
	Children and young people	Good (2020)	DMA Canx by CQC due to Covid - Feb 22
	End of life care	Good (2018)	DMA Canx by CQC due to Covid - Mar 22
	Outpatients	Good (2018)	DMA – Dec 2022
	Diagnostic imaging	N/A	
Community health	Community adults	Outstanding (2016)	
	Community children and young people	Good (2018)	
	Community inpatients	Good (2020)	
	Community end of life	Requires improvement (2018)	
	Community dental	Outstanding (2016)	
	Community urgent care	Good (2016)	
Mental health	Substance misuse	N/A	
Ambulance	Patient transport services	Outstanding (2016)	DMA Sept 2022
Adult social care	St Edmunds	Good (2018)	

During 2021/22, the Trust continued, despite the Covid pandemic, to progress its improvement plan following the March 2020 CQC inspection. This inspection resulted in 28 Must do and 46 Should Do improvement actions. In April 2022 9 Must Do and 8 Should Do actions remain open. These actions fall into 4 main themes that had been greatly affected by the pandemic: Training compliance, Appraisal compliance, Trustwide clutter and a rolling medical devices replacement programme. The Trust and ISUs continue to work to close these actions and the revised date for close is set for Sept 2022

Of the immense Trust wide work that has resulted in the closure of Must do and 38 Should Do actions, the following is a selection of the work that has been undertaken:

The CQC said we must ensure the Trust has a clear oversight of compliance with resuscitation training levels, to include intermediate and advanced life support training for adults and paediatrics, and that we can assure ourselves that our staff are up to date with their training needs and the patients are ultimately safe.

In response to this an improvement plan was created via the Education team. Their first steps were to look at the Training Needs Analysis document and obtain the numbers of staff, Trust requirements for intermediate and advanced needs and carry out a gap analysis. Once achieved this allowed for courses to be provided at each level and reports generated to show the growing compliance rate.

The CQC also required The Children's and Young Persons service to ensure they can evidence compliance of paediatric resuscitation in the training needs analysis and this has been fully completed too.

The Resuscitation Committee also helped to monitor the progress of this action

With the new starters included in the reporting mechanisms, a really robust monitoring system is in place, which gives monthly feedback to managers on compliance.

The maternity team were tasked with improving the Maternity Early Obstetric Warning Score (MEOWS) assessment in line with policy. MEOWS is a tool used to help identify deterioration in women and ensure appropriate early intervention is started. The team, through a Task and Finish Group, reviewed the current situation, formulated an improvement plan, carried out the interventions and monitored the outcome through a 12-week audit process the results of which showed compliance higher than the target rate of 80% compliance. The team are continuing to look to improve MEOWS and are looking at electronic versions.

Maternity had also focused on ensuring safety checks on equipment was 100% compliant. Through Key Performance Indicators, Maternity wide communications and Audit, the checks are running at 100% compliance

The Team have also been improving Medical Staff training compliance, this has proved

challenging through the Covid pandemic but training development plans, monthly monitoring and Governance oversight has this action been achieved and this compliance will help with the Clinical Negligence Scheme for Trusts (CNST) processes Maternity has to comply with.

Maternity have shown great teamwork and planning in achieving their CQC Improvement plan objectives.

Our CQC website, under continued improvements in my area has many more of the actions taken to ensure and enhance the care we give

6. CQC's Ongoing Monitoring of the Trust

The local CQC inspectors and the Trust have continued to engage throughout the pandemic and maintain a good working professional relationship.

The Trust has continued to receive routine enquiries from the CQC, as part of their ongoing monitoring of the Trust. The local CQC inspectors request additional information on specific concerns relating to services provided by the Trust, such as specific complaints, safeguarding concerns and patient-related incidents. All of these events are routinely managed internally by TSDFT through established processes and governance routes. When the information on the specific events requested becomes available it is passed to the CQC. The CQC also raises enquiries from feedback received directly by the them, in regards to the services provided by the Trust, to which the Trust will provide a timely response.

To monitor this process the Trust meets the CQC inspectors formally, via the monthly Open Enquiry meetings. These meetings are 1 hour long and are carried out via teams. They are an opportunity to formally discuss issues that have come to the Inspectors attention, and review Safeguarding, Complaints and Clinical Incidents. They also receive updates on the ongoing CQC Must Do improvement action plans.

On a quarterly basis the Trust manages a CQC Engagement meeting. This is a 3-hour meeting and generally involves presentations from the Chief Nurse, Chief Operating Officer and the Chief Executive on Trustwide issues. It may also include presentations or discussions from specific teams, for example, Maternity, People Partners, re topical issues such as the Ockenden report or the NHS Staff Survey. The CQC also update the Trust on their national and regional issues or key findings, as appropriate. The meetings provide a valuable opportunity to share positive stories, and practices and to update the CQC around any concerns relating to specific services. These meetings have been invaluable during Covid.

In 2021/22 the CQC introduced a procedure called Direct Monitoring Approach (DMA), this being a key facet of its new strategy of regular and ongoing assessment of Trust core services via data and compliance. The CQC pose a number of written questions to a specific area in advance, based on their 5 key questions and Key lines of Enquiry, which the area then answers through data, policy and narrative. These documents are discussed and reviewed via the hourly meeting. To date Urgent and Emergency Care, Maternity, Surgical, Medical, Patient Transport & Outpatients Department have had

DMAs. Four planned DMAs were cancelled by the CQC as they stepped down inspection activity during the 3rd wave of Covid, over the 2021/22 winter period.

From these DMAs, the CQC have identified no issues and no further action was required. The teams found them very beneficial and allowed them to showcase any quality improvement work or best practice they had undertaken.

Overall the engagement activity with the CQC in 2021/22 has been very positive, and the new relationships built this year with the 2 new local CQC inspectors has been very productive.

7. Ongoing Assurance and Preparation for future monitoring/inspection visits

Well-Led

Building on the independent Well Led review undertaken by Deloitte in 2020, the Trust has taken a number of steps to strengthen systems of governance under the following headings and by the following actions, (please note these are only a selection from the full action plan):

Leadership

- Further development of the Board & Executive Team Development Programme
- Review of roles and working arrangements via portfolio review
- Development of a Board Concordat
- NED Skill set review

Vision & Strategy

- Strategic Development Group established
- Executive Lead for coordination & integration of the Corporate Strategy
- Strategic Alliance Partnership Board for coordinating the Heath & Care Strategy

Culture

- Successful appointment to the position of Health & Care Strategy Director
- Professional Leaders Group in place chaired by Chief Nurse
- NEDs portfolio and experience reflects the breadth of our community experiences
- Refresh of the Communication's & Engagement Strategy
- Completed review of staff feedback processes

Risks & Performance

- Summary Dashboard presented with the Board Assurance Framework
- Board cover sheets include reference to BAF corporate objectives
- New QIA Framework agreed by QAC in July 2021 and implemented

Stake Holder Engagement

- Planned in person engagement programme limited due to Covid
- Patient experience and engagement conference held and vision and objectives agreed
- Communications and engagement strategy has been developed and due to Board in October 2021

The Trust established an Executive Review Programme to seek further assurance around improvements reported at Core Service level. The aim was to review evidence of improvement work in relation to their Must Do improvement actions, following the 2020 CQC inspection. These occurred over a number of days and via a combination of Teams, Face to Face (F2F) presentations and/or area visits. The review was supported by the Internal Audit team who also acted as an independent critical friend in the process. The formal evaluation of the programme has been given by Internal Audit to the board which showed the process to be very positive and beneficial.

Core services presented their evidence with a view to Executive assessment determining the improvement action having n=been met, partially met or requiring further evidence to assure closure. The process was carried out in a positive manor and of the 29 Must Do Improvement actions, 9 remain open. These actions fall into 4 main themes that had been greatly affected by the pandemic: Training compliance, Appraisal compliance, Trustwide clutter and a rolling medical devices replacement programme.

These actions continue to be monitored at the Trusts CQC assurance group.

Of the improvement actions closed, the variety and volume of work that has been generated during Covid to close them has been very positive.

Evidence via the Ward Accreditation System
The Ward Accreditation system provides objective assessment of wards and departments against a framework of international standards, including the CQC fundamental standards. Action planning by the Ward Manager and Matron follows a review, to enable the ward or department to improve towards or maintain the highest rating. The Ward Accreditation system is part of the wider Nursing and Midwifery Excellence programme, a collaborative approach ensuring oversight and assurance of the key components of nursing and midwifery at Torbay. The Ward Accreditation system is well received by wards and departments.

Peer to Peer review
In 2021/22, a clinically-led peer-to-peer review process for TSDFT was developed and implemented within the Covid limitations.
The aim was for quality improvement through assessment, enquiry and learning between peers.

The process was designed to:
- be positive, supportive experience and provide a ‘critical friend’ to encourage reflection and improvement
- look at evidence against the CQCs KLOEs

- fit with the new Ward Accreditation Scheme, and the leadership and patient safety walkarounds.

From our findings in 2021/22 a new process is being formulated to match the new CQC strategy as they are a valued and productive way to help prepare staff for any inspection or area enquiry. The new approach is being built on the 15 steps and 'fresh eyes approach' and will be more inclusive of different staff at the appropriate grade who use or access the ward areas.

CQC Continuous Assurance Group
The group retains a healthy membership, a high attendance rate and is a key focal point to share CQC information regarding local/national inspections of other Trusts, key publications, the CQC's bi-monthly Insight tool, progress against the CQC actions plans, DMAs, and debate of key issues. The group continues to report monthly to the Quality Improvement Group and bi-monthly to the Quality Assurance Committee.

Internal Website
The Trusts CQC website has been reviewed and developed and is the source for all CQC information. The site includes helpful tips and guides as well as formal assessments and booklets to help staff prepare for a CQC visit. The site also includes the ward infographics of all they have achieved in relation to the Must Do Should Do improvement action journey, newsletters and inspection reports.

8. Conclusion

For assurance, this report has provided an annual update to the Quality Assurance Committee on the Trust's: current registration status; compliance with the CQC standards; response to previous CQC inspections; CQC's monitoring activity, and the preparation for future inspections and monitoring activity. This is in addition to the bi-monthly reports submitted to QAC.

9. Recommendations

The Trust Board is asked to receive and note:

- the Statement of Purpose
- Changes to CQC Regulatory approach
- Update on Trust actions against findings from recent inspections
- Preparation for future monitoring

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Freedom to Speak Up Guardian Six Monthly Report			Meeting date: 25 May 2022
Report appendix	Freedom to Speak Up Work Plan		
Report sponsor	Lead Executive for Freedom to Speak Up		
Report author	Lead Freedom to Speak Up Guardian		
Report provenance	NHS National Contract		
Purpose of the report and key issues for consideration/decision	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors are asked to receive and note the Freedom to Speak Up Guardian Six Monthly Report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience		**Valuing our workforce**	x
Improved wellbeing through partnership		**Well-led**	x

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
NHS England	**x**	**National policy/guidance**	**x**

Report title: Freedom to Speak Up Six Monthly Report		Meeting date: 25 May 2022
Report sponsor	Lead Executive for Freedom to Speak Up	
Report author	Lead Freedom to Speak up Guardian	

1.0 Introduction

1.1 Speaking up protects patients and workers, but is only effective if leaders listen up and follow up with leaders setting the tone from the top. Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job. That can be about ideas for improvement, ways of working or behaviours.

2.0 Assessment of cases

2.1 Since the last Board report in October there have been 34 concerns raised through the Freedom to Speak Up Guardians. The highest number of cases relate to poor cultures within teams and departments followed by bullying and harassment. There has been an increase in staff raising concerns about standards of care and patient safety.

Bullying and Harassment - 10
Patient Safety - 7
Failure to follow process - 2
Diversity and Inclusion - 1
Staff Safety - 3
Culture of organisation – 11
Fraud – 0

2.3 Staff group speaking up included:
Medical - 2
Nurse - 10
Midwife - 0
AHP - 5
Senior Manager - 3
HCSW/AP - 5
A&C – 6
EFM - 3

2.4 Highest staff number speaking up were nurses, admin and clerical staff followed by allied health professionals.

2.5 Poor culture within teams and departments included not feeling listened to, lack of communication and lack of feedback on concerns.

2.6 Bullying and harassment remains in the top three concerns raised which is consistent with an increase in staff reporting that they have experienced this behaviour. Reporting bullying and harassment was in the top five most improved questions in the National Staff Survey.

2.7 Standards of patient care and concerns for patient safety and dignity have increased in the last six months. This clearly correlates with the National Staff Survey findings for 2021 where there has been a 4.1% increase in staff feeling safe to raise concerns about unsafe clinical practice. This is the most significant increase in the survey.

3.0 Feedback from speaking up

These are an example of quotes from individuals who have received support from the Freedom to Speak Up Guardians, demonstrating the positive impact of the roles:

I am not sure you know how much your help has meant to me

Thank you so much for our conversation. You were just so supportive and I can't thank you enough.

There are so many staff that are feeling so grateful for your help.

Thanks again for all the support you gave, the hospital could do with ten of you.

4.0 Actions to continue to improve FTSU culture

However, staff feeling safe to speak up about anything that concerns them has declined by 3.1% in the National Staff Survey. An anonymous user-friendly platform would seek to address this.

4.1 WorkInConfidence: Protect: Anonymous Speak up: A safe and secure online system for staff to raise issues and surface concerns anonymously through the Freedom to Speak Up Guardians.
To be launched by Chief Executive and Executive Lead for Speaking Up as part of Every Voice Counts in Our People Promise.

4.2 Consolidated Case Management: Alongside Protect: Anonymous Speak Up there is a consolidated case management system where all matters which are of a Speak Up nature can be logged whether they are raised through the platform or not.

4.3 Freedom to Speak Up training - 'Speak Up, Listen Up, Follow Up' - is freely available for everyone who works in healthcare. Divided into three modules, it helps people understand the vital role we all play in a healthy speaking up culture which protects patients and service users and enhances worker experience.

Speak Up is part of the induction package for new starters.

Listen up will be available for managers and promoted through the Hive.

Follow Up – completes the package. Developed for senior leaders throughout healthcare, including executive and non-executive directors, lay members and governors. The module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken.

5.0 Freedom to Speak Up Work Plan

The Freedom to Speak up Work Plan contains the actions needed to comply with the Freedom to Speak up review tool for NHS Trusts and Foundation Trusts published in 2019. All actions have now been completed with apart from

- Requirement for senior leaders to complete the **Follow Up** training as mentioned previously in **4.3** of this report.

- Directors fulfilling speak up responsibilities is being integrated as part of the next round of objective setting starting imminently.

- Review of the FTSU Champion role with an option of linking it to the Wellbeing Buddy network.

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Freedom to Speak Up Guardian WORK PLAN: April 2021				
Act No	**Action**	**Action Assigned To**	**Deadline**	**Progress**
1.0 Priorities arising from self assessment				
1.1	To arrange Board Development session	Sarah Burns	Sept 22	NGO Follow up training for Senior Leaders now available
1.2	To ensure Directors are able to evidence they are fulfilling speak up responsibilities.	Judy Falcao	June 22	To be part of current objective setting.
1.3	To progress actions to address bullying, harassment & abuse	Jenny Shepherd	Complete	As part of the PP&P anti bullying advisor network has been established and launched (April). On line induction training is in development and will be followed by mandatory training as part of conflict resolution.
1.4	To develop processes and support for staff who feel they suffer a detriment as a result of speaking up	Sarah Burns	Complete	
2.0 Review of Model				
2.1	Redefine the expectation of the Guardian role. To include expectation about case work and predicted increase given the procurement of the communication platform	Sarah Burns		Complete
2.2	Individual conversations with the Guardian network to understand their intention given the redefined role	Sarah Burns		Complete
2.3	Develop resources and programme to support wide scale recruitment of FTSU champions. To include; • Induction programme • Buddy system • On going training	Sarah Burns	Sept 22	Induction resource in place. Current Champion model under review with potential to link with Wellbeing Buddy network.

2.4	Explore the appetite across the system to access other Guardians networks as a means of providing greater independence in set circumstances	Sarah Burns		Complete.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors		
Report title: Refresh of the Trust Constitution		**Meeting date**: 25 May 2022
Report appendix	Appendix 1: Trust Constitution with proposed amendments	
Report sponsor	Interim Director of Corporate Governance and Trust Secretary	
Report author	Corporate Governance Manager	
Report provenance	Council of Governors	
Purpose of the report and key issues for consideration/decision	Following a review of the Trust's Constitution by Browne Jacobson Solicitors, a number of updates are proposed to ensure the Constitution is brought in line with current legislation and best practice. It is also proposed that a new constituency is added to reflect the Trust's role in the wider system. This would also enable applicants to non-executive positions who live outside of the Trust's original footprint to apply for such posts. A summary of key changes to the constitution is as follow: S.24 – Amendment to reflect the provisions of the law on NEDs and EDs appointments. Annex 1 – Introduction of the Rest of the South-West Peninsula constituency Annex 3 – Increase in the number of governors from 32 to 33 Annex 4 – Deletion of Model Election Rules which is considered to be irrelevant. The process for amendment of the constitution as stated at section 47 is as follow: The Trust may make amendments of its Constitution only if: • more than half of the members of the Council of Governors of the Trust voting approve the amendments; and • more than half of the members of the Board of Directors of the Trust voting approve the amendments. It also stipulates that: Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust): • at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and	

	• the Trust must give the members an opportunity to vote on whether they approve the amendment. • if more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. • amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act. The proposed amendments to the Constitution have been reviewed and discussed by a Governor Working Group, and unanimously approved by the Trust Council of Governors at its meeting held on the 4th May 2022. Since the amendments proposed do not relate to the powers or duties of the Council of Governors, the constitution becomes a working document if approved by majority of the voting members of the Board of Directors today.

Action required	**For information** ☐	**To receive and note** ☐	**To approve** ☒

Recommendations	The Board is asked: • To approve the proposed changes to the Trust's Constitution; • To note that the constitution will become a working document upon approval today; and • To note that the Monitor will be notified of the changes to the constitution as required.

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience		**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks	**Care Quality Commission**		**Terms of Authorisation**	X
	NHS Improvement	X	**Legislation**	X
	NHS England	X	**National policy/guidance**	X

Torbay and South Devon NHS Foundation Trust

Constitution

Approved by Council of Governors 4 May 2022~~5 August 2020~~

Torbay and South Devon NHS Foundation Trust Constitution

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1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 11 of the constitution.

constitution means this constitution and all annexes to it.

Model Election Rules means the rules for the conduct of elections for the member of council of governors of NHS foundation trusts, which at the date of this Constitution are published by NHS Providers.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. Name

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

3. Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England[1].

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

[1] ~~The principal purpose is as set out in sub-section 43(1) of the 2006 Act and must be included in the constitution by virtue of paragraph 2(2). The paragraphs which follow reflect other provisions in section 43.~~

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

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

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4.4 Where the Trust is exercising functions of the managers pursuant to Section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an executive director of the Trust nor an employee of the Trust.

5. Membership and constituencies

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

5.1 a public constituency; and

5.2 a staff constituency.

6. Application for membership

An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into six (6) descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.6 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency; and

9.1.2 invited by the Trust to become a member of the Staff Constituency;

shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

9.2 The Secretary shall make the final decision about the Constituency an individual shall be eligible to be a member.

10. Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least fourteen (14) years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 89 – Further Provisions.

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 78 – Annual Members' Meeting.

12. Council of Governors – composition

12.1 The Trust is to have a Council of Governors which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13. Council of Governors – election of governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules on the basis of single transferable vote (STV) polling and the Model Election Rules shall

be construed accordingly.

13.2 The Model Election Rules as published from time to time by NHS Providers form part of this constitution. ~~The Model Election Rules current at the time of their adoption under this constitution are attached at Annex 4.~~

13.3 A subsequent variation of the Model Election Rules by NHS Providers, or any other subsequent body with the authority to do so, shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors - tenure

14.1 An elected governor may hold office for a period of three (3) years. ~~consecutive terms up to a maximum period of nine (9) years.~~

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term. An elected governor may hold office (whether for the same constituency or class or for different constituencies or classes) for consecutive terms up to a maximum period of nine (9) years. Terms of office are consecutive where there is a break of not more than 12 months between them.

14.4 An appointed governor may hold office for a period of up to nine (9) years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

~~14.6~~14.7 Prior to an election for any elected governor position, the Chair may, having consulted the Lead Governor and acting reasonably in all the circumstances, determine that the term of office for the governor elected shall be shorter than 3 years in order to ensure that turnover of governors at future elections will not be excessive. Notice of this decision shall be given prior to the election.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of

Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.3 a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

15.1.4 a person is the subject of a sex offenders order;

15.1.5 a person in relation to whom a moratorium period under debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.6 a person whose tenure as a governor has been terminated in accordance with paragraph 4.4 and/or 4.5 of Annex 4~~5~~; or

15.1.7 a person whose tenure as a governor of the Trust or another foundation trust has been terminated for cause.

15.1 A Further provisions about eligibility are set out in Annex ~~6~~5.

15.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 4~~5~~.

16. Council of Governors – vacancies

16.1 Where membership of the Council of Governors ceases for reasons of removal or resignation, public and staff governors shall be replaced in accordance with the following procedure:

16.2 Replacement will be by selecting the person with the next highest allocation of votes in the previous election for the constituency or class represented. The replacement governor shall serve the remainder of the term of office vacated by the previous governor. If there is no such person, then the seat shall remain vacant until the next annual election is held.

17. Council of Governors – duties of governors

17.1 The general duties of the Council of Governors are:

17.1.1 to hold the non-executive directors individually and collectively to

account for the performance of the Board of Directors; and to represent the interests of the members of the Trust as a whole and the interests of the public. This will be achieved in line with NHSE/I guidance.

17.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

~~The remuneration of governors by their respective employer.~~

18. Council of Governors – meetings of governors

18.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 27 below) or, in his absence, the Vice Chairman (appointed in accordance with the provisions of paragraph 29 below), shall preside at meetings of the Council of Governors.

18.2 In the absence of either the Chairman or Vice Chairman at a meeting of the Council of Governors, the governors present shall nominate another non-executive director to preside at that meeting.

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

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

19. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 5~~6~~.

20. Council of Governors – referral to the Panel

Not used

21. Council of Governors – conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose

that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

22. Council of Governors – travel expenses and remuneration

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. Governors shall not be entitled to receive remuneration.

23. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 45.

24. Board of Directors – composition

24.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chairman;

24.2.2 ~~not less than five (5) and no greater than eight (8)~~ other non-executive directors; and

24.2.3 ~~not less than four (4) and no more than seven (7)~~ executive directors.

24.3 One of the executive directors shall be the Chief Executive.

24.4 The Chief Executive shall be the Accounting Officer.

24.5 One of the executive directors shall be the chief finance officer.

24.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.7 One of the executive directors is to be a registered nurse or a registered midwife.

24.8 The non-executive directors and Chairman together shall be greater than the total number of executive directors.

24.9 The validity of any act of the Trust is not affected by any vacancy among the directors of by any defect in the appointment of any director.

25. Board of Directors – general duty

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

26. Board of Directors – qualification for appointment as a non-executive director

26.1 A person may be appointed as a non-executive director only if:

26.1.1 he is a member of a Public Constituency; or
26.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university; and
26.1.3 he is not disqualified by virtue of paragraph 32 below.

26.2 The Chairman and non-executive directors must on appointment and for each and every term of office, meet the Independence Criteria. In the event a non-executive director or the Chairman has served on the Board for more than nine (9) years, he shall be replaced and the Council of Governors shall appoint a non-executive director in his place.

26.3 The Independence Criteria means that the Chairman and non-executive directors on appointment and throughout their term of office must not:

26.3.1 have been an employee of the Trust within the last five (5) years;
26.3.2 receive or have received additional remuneration from the Trust (apart from a director's fee), participate in the Trust's performance related pay scheme (if any) or be, or have been a member of the Trust's pension scheme;
26.3.3 have any close family tie with any director, senior employee or professional advisor to the Trust;
26.3.4 not have any significant business link with any director of the Trust, including through involvement in any company or body; or
26.3.5 have served on the Trust Board of Directors for more than nine years from the date of their first appointment.

26.4 The Chairman may not previously have been the Chief Executive of the Trust.

27. Board of Directors – appointment and removal of chairman and other non-executive directors

27.1 A nominations committee shall be established to make recommendations to the Council of Governors on the appointment of the Chairman and

Council of Governors.

27.2 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the Trust and the other non-executive directors.

27.3 Appointment of the Chairman or a non-executive director shall require the approval of a majority of the members of the Council of Governors.

27.4 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

28. Not used

29. Board of Directors – appointment of Vice Chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a Vice Chairman. If the Chairman is unable to discharge his duties as Chairman of the Trust, the Vice Chairman shall be Acting Chairman of the Trust.

30. Board of Directors - appointment and removal of the Chief Executive and other executive directors

30.1 The non-executive directors shall appoint or remove the Chief Executive.

30.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

30.3 Not used

30.4 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. The Chairman shall act as the chair of such committee.

31. Not used

32. Board of Directors – disqualification

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

32.1 a person who falls within the definition of an “unfit person” as defined by the Trust’s Provider Licence, the Health and Social Care Act (2012) (Regulated Activities) Regulations and the Trust’s Constitution;

32.2 a person who has been adjudged bankrupt or whose estate has been

sequestrated and (in either case) has not been discharged;

32.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

32.4 a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

32.5 a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

32.6 a person who has had their name removed, by a direction under section 151 of the 2006 Act from any relevant list, and has not subsequently had his name included on such a list;

32.7 a person who is the subject of a sex offender's order;

32.8 a person who on the basis of disclosure obtained through a DBS check, he is not considered suitable by the Chairman on the advice of the Trust's director responsible for human resources;

32.9 a person whose tenure of office as an officer or director of a health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of pecuniary interests;

32.10 a person who within the preceding five years been dismissed, otherwise than by reason of redundancy or ill health from any paid employment with a health service body;

32.11 in the case of a non-executive director, he no longer satisfies paragraph 26;

32.12 a person who has been removed from trusteeship of a charity;

32.13 a person who is the spouse, partner, or child of a member of the Board of Directors;

32.14 in the case of a non-executive director, a person who has refused without reasonable cause to fulfill any training requirement established by the Board of Directors or refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors;

32.15 on the basis of disclosures obtained through an application by the Disclosure Barring Service, they are not considered suitable by the Chairman on the advice of the Trust's director responsible for human resources; or

32.16 in the case of a non-executive director, a person who has refused without reasonable cause to fulfil any training requirement established by the Board of Directors, or refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

33. Board of Directors – meetings

33.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

33.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting (and prior to the next meeting), the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. A meeting held in private shall not be covered by this clause.

34. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 6~~7~~.

35. Board of Directors - conflicts of interest of directors

35.1 The duties that a director of the Trust has by virtue of being a director include in particular:

35.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; or

35.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

35.2 The duty referred to in sub-paragraph 35.1.1 is not infringed if:

35.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

35.2.2 the matter has been authorised in accordance with the constitution.

35.3 The duty referred to in sub-paragraph 35.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

35.4 In sub-paragraph 35.1.2, “third party” means a person other than:

35.4.1 the Trust; or

35.4.2 a person acting on its behalf.

35.5 If a director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

35.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

35.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

35.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

35.9 A director need not declare an interest:

35.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

35.9.2 if, or to the extent that, the directors are already aware of it; or

35.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:

35.9.3.1 by a meeting of the Board of Directors; or

35.9.3.2 by a committee of the directors appointed for the purpose under the constitution.

35.10 A matter shall have been authorised for the purposes of paragraph 35.2.2 if:

35.10.1 the Board of Directors by majority disapplies the provision of the Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

35.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

35.10.3 the director's conflict of interest arises from a permitted clause (as determined by the Board of Directors) from time to time.

36. Board of Directors – remuneration and terms of office

36.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

36.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive, other executive directors, and other senior staff.

37. Registers

The Trust shall have:

37.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;
37.2 a register of members of the Council of Governors, the class of constituency of which they are a member and an address through which they may be contacted (which may be the Secretary);
37.3 a register of interests of governors;
37.4 a register of directors, their capacity on the board and an address through which they be contacted (which may be the Secretary); and
37.5 a register of interests of the directors.

38. <u>Admission to and removal from the registers</u>

38.1 The Secretary (or their nominee) shall add to the register of members the name of an individual who is accepted as a member of the Trust under the provisions of this Constitution as soon as is reasonably practicable.

38.2 The Secretary (or their nominee) shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of the Constitution as soon as is reasonably practicable.

39. <u>Registers – inspection and copies</u>

39.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

39.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

39.3 So far as the registers are required to be made available:

39.3.1 they are to be available for inspection free of charge at all reasonable times; and
39.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

39.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

40. <u>Documents available for public inspection</u>

40.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

40.1.1 a copy of the current Constitution;
40.1.2 a copy of the latest annual accounts and of any report of the auditor on them;
40.1.3 a copy of the latest annual report; and
40.1.4 a copy of the latest information as to its forward planning.

40.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

40.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act;
40.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;
40.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act;
40.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;
40.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;
40.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;
40.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;
40.2.8 a copy of any final report published under section 65I (administrator's final report);
40.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and
40.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

40.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. Auditor

41.1 The Trust shall have an auditor.

41.2 The Council of Governors shall appoint or remove the auditor, on the recommendation of the Audit Committee, at a general meeting of the Council of Governors.

42. Audit Committee

The Trust shall establish a committee of non-executive directors (comprising of at least three (3) independent non-executive directors) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

43. Accounts

43.1 The Trust must keep proper accounts and proper records in relation to the accounts.

43.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

43.3 The accounts are to be audited by the Trust's auditor.

43.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

43.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

44. Annual report, forward plans and non-NHS work

44.1 The Trust shall prepare an Annual Report and send it to Monitor.

44.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

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

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

44.5 Each forward plan must include information about:

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

44.5.2 the income it expects to receive from doing so.

44.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

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

44.6.2 notify the directors of the Trust of its determination.

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

45. Presentation of the annual accounts and reports to the governors and members

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

45.1.1 the annual accounts;

45.1.2 any report of the auditor on them;

45.1.3 the annual report;

45.1.4 membership information, and any report on progress of the membership strategy; and

45.1.5 register of governors' interest.

45.2 The documents listed in 45.1.1, 45.1.2, and 45.1.3 shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

45.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 45.1 with the Annual Members' Meeting.

46. Instruments

46.1 The Trust shall have a seal.

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

47. Amendment of the constitution

47.1 The Trust may make amendments of its Constitution only if:

47.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments; and

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

47.2 Amendments made under paragraph 47.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

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

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

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

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

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

48. Mergers etc. and significant transactions

48.1 The Trust may only apply for a merger, acquisition, separation or dissolution (any of which is a statutory transaction) with the approval of more than half of the members of the Council of Governors.

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

48.3 "Significant transaction" means a transaction which is not a statutory transaction but meets any one (1) of the following criteria:

48.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's annual turnover before acquisition;

48.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the Trust's annual turnover before the disposition; or

48.3.3 the transaction has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's annual turnover before the transaction.

48.4 For the purpose of this paragraph, in assessing the value of any contingent liability for the purposes of paragraph 48.3 the directors:

48.4.1 must have regard to all circumstances that the directors know, or ought to know, affect, or may affect, the value of the contingent liability;

48.4.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

48.4.3 may take account of the likelihood of the contingency occurring.

48.5 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed the threshold of 10% for any of the criteria set out in paragraph 48 above.

48.6 A transaction excludes:

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

48.6.2 any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services.

49. Indemnity

49.1 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, the Council of Governors, the Board of Directors, and the Secretary.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

The Trust has four (4) Public Constituenciesy ~~is divided in to three (3) classes~~ as follows:

Areas comprising the Public Constituency	**Local Authority areas/or local authority electoral areas falling within the following Electoral Wards**	**Minimum number of Members**	**Number of elected Governors**
South Hams and Plymouth	South Hams Local Authority City of Plymouth Unitary Authority Electoral wards: Plympton Chaddlewood, Plympton St Mary, Plympton Erle, Plympton Dunstock and Plymstock Radford	Five hundred (500)	Three (3)
Torbay	Torbay Unitary Authority	Five hundred (500)	Seven (7)
Teignbridge	Teignbridge District Council	Five hundred (500)	Seven (7)
Rest of the South West Peninsula	All electoral wards in Cornwall, Devon, Somerset and Bristol not included in the above Public Constituencies	Ten (10)	One (1)

ANNEX 2 – THE STAFF CONSTITUENCY

The Staff Constituency is divided in to six (6) classes as follows:

Classes comprising the Staff Constituency	Minimum number of Members	Number of elected Governors
Coastal Integrated Service Unit	One hundred (100)	One (1)
Moor to Sea Integrated Service Unit	One hundred (100)	One (1)
Newton Abbot Integrated Service Unit	One hundred (100)	One (1)
Paignton and Brixham Integrated Service Unit	One hundred (100)	One (1)
Torquay Integrated Service Unit	One hundred (100)	One (1)
Trustwide Operations and Corporate Services Integrated Service Unit	One hundred (100)	One (1)

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors shall comprise ~~32~~ 33 Governors comprised as set out below and illustrated in the following table:

- ~~Seventeen~~ Eighteen (~~17~~18) Governors elected by members of the Trust from the Public ~~Constituency~~ Constituencies with each ~~area~~ Public Constituency ~~appointing~~ electing the number of Governors as set out in the table below:

- Six (6) Governors selected by the Staff Constituency, with the following number of Governors elected from each class within the Staff Constituency by that class:

Coastal Integrated Service Unit	1
Moor to Sea Integrated Service Unit	1
Newton Abbot Integrated Service Unit	1
Paignton and Brixham Integrated Service Unit	1
Torquay Integrated Service Unit	1
Trustwide Operations and Corporate Services Integrated Service Unit	1

- One (1) Governor appointed by each of the following local authorities or any successor local authority for an area which includes the whole or part of an area forming part of the South Hams and Plymouth, Torbay or Teignbridge Public Constituenc~~y~~ies ~~set out at Appendix~~ Annex 1:

  South Hams District Council
  Teignbridge District Council
  Torbay Unitary Authority

- One (1) Governor appointed by Devon County Council

- One (1) Governor appointed by NHS Devon Clinical Commissioning Group

- One (1) Governor appointed by Devon Partnership NHS Trust

- One (1) Governor appointed by each of the following universities:

  University of Exeter Medical School
  Plymouth University Peninsula School of Medicine and Dentistry

- One (1) Governor appointed by Devon Carers Strategy Board and/or Torbay Carers Strategy Steering Group

Table:

Public Constituency	**Number of Public Governor seats**	
South Hams and Plymouth		**3**
Teignbridge		**7**
Torbay		**7**
Rest of the South West Peninsula		**1**
	Sub Total	**~~17~~18**
Staff Constituency	**Number of Staff Governor seats**	
Coastal Integrated Service Unit		**1**
Moor to Sea Integrated Service Unit		**1**
Newton Abbot Integrated Service Unit		**1**
Paignton and Brixham Integrated Service Unit		**1**
Torquay Integrated Service Unit		**1**
Trustwide Operations and Corporate Services Integrated Service Unit		**1**
	Sub Total	**6**
Appointed Governors' Constituency		
Devon County Council		**1**
South Hams District Council		**1**
Teignbridge District Council		**1**
Torbay District Council		**1**
NHS Devon Clinical Commissioning Group		**1**
Devon Partnership NHS Trust		**1**
University of Exeter Medical School		**1**
Plymouth University Peninsula School of Medicine and Dentistry		**1**
Voluntary Sector: Devon Carers		**1**
	Sub Total	**9**
	Total	**~~32~~33**

ANNEX 4 –~~THE MODEL ELECTION RULES~~NOT USED

~~**PART 1: INTERPRETATION**~~

~~1. Interpretation~~

~~**PART 2: TIMETABLE FOR ELECTION**~~

~~2. Timetable~~
~~3. Computation of time~~

~~**PART 3: RETURNING OFFICER**~~

~~4. Returning officer~~
~~5. Staff~~
~~6. Expenditure~~
~~7. Duty of co-operation~~

~~**PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS**~~

~~8. Notice of election~~
~~9. Nomination of candidates~~
~~10. Candidate's particulars~~
~~11. Declaration of interests~~
~~12. Declaration of eligibility~~
~~13. Signature of candidate~~
~~14. Decisions as to validity of nomination forms~~
~~15. Publication of statement of nominated candidates~~
~~16. Inspection of statement of nominated candidates and nomination forms~~
~~17. Withdrawal of candidates~~
~~18. Method of election~~

~~**PART 5: CONTESTED ELECTIONS**~~

~~19. Poll to be taken by ballot~~
~~20. The ballot paper~~
~~21. The declaration of identity (public and patient constituencies)~~

~~*Action to be taken before the poll*~~

~~22. List of eligible voters~~
~~23. Notice of poll~~
~~24. Issue of voting information by returning officer~~
~~25. Ballot paper envelope and covering envelope~~
~~26. E-voting systems~~

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code;

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b);

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

~~"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;~~

~~"*telephone voting facility*" has the meaning set out in rule 26.2;~~

~~"*telephone voting record*" has the meaning set out in rule 26.5 (d);~~

~~"*text message voting facility*" has the meaning set out in rule 26.3;~~

~~"*text voting record*" has the meaning set out in rule 26.6 (d);~~

~~"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;~~

~~"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;~~

~~"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting; and~~

~~"*voting information*" means postal voting information and/or e-voting information.~~

~~1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.~~

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday; or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules; and

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(c) the details of any nomination committee that has been established by the corporation;

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer;

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form; and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name;

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication); and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation; and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;

(b) decides that the nomination form is invalid;

(c) receives satisfactory proof that the candidate has died; or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election;

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) that the paper does not include a declaration of eligibility as required by rule 12; or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing; and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an

~~election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:~~

~~(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules; and~~

~~(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.~~

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed; and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated;

(b) that he or she has not marked or returned any other voting information in the election; and

(c) the particulars of his or her qualification to vote as a member

of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and

(b) the member's e-mail address, if this has been provided,

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters forwhom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3;

(g) the address for return of the ballot papers;

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located;

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located;

(k) the date and time of the close of the poll;

(l) the address and final dates for applications for replacement voting information; and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) the ID declaration form (if required);

(c) information about each candidate standing for election, pursuant to rule 61 of these rules; and

(d) a covering envelope.

("postal voting information")

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required);

(b) the voter's voter ID number;

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate; and

(d) contact details of the returning officer.

("e-voting information")

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information,

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed ID declaration form if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone systemfor the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election is being held;

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(v) instructions on how to vote and how to make a declaration of identity;

(vi) the date and time of the close of the poll; and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter

using the internet that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote;

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election is being held;

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) instructions on how to vote and how to make a declaration of identity;

(v) the date and time of the close of the poll; and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote;

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote;

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter

to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter;

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter;

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it); and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity;

(b) has no reason to doubt that the voter did not receive the original voting information; and

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter;

(b) the details of the unique identifier of the replacement ballot paper, if applicable; and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter;

(b) the unique identifier of any replacement ballot paper issued under this rule; and

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope; or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified";

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper;

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency) [1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified";

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

from the voter without a ballot paper; and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified";

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper;

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified";

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet; and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;

(b) the ID declaration forms, if required;

(c) the list of spoilt ballot papers and the list of spoilt text message votes;

(d) the list of lost ballot documents;

(e) the list of eligible voters; and

(f) the list of tendered voting information,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record;

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded;

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;

"*mark*" means a figure, an identifiable written word, or a mark such as "X";

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate

or

(b) which is excluded by the returning officer under rule STV49;

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference;

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;

"*quota*" means the number calculated in accordance with rule STV46;

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus;

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate;

(b) the transfer of a surplus of a candidate deemed to be elected; or

(c) the exclusion of one or more candidates at any given time;

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred; and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election; and

(ii) a policy governing the use of such software; and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created; and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;

(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;

(b) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) on which votes are given for more candidates than the voter is entitled to vote;

(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place;

(b) otherwise than by means of a clear mark; or

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

~~FPP44.4 The returning officer is to:~~

~~(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted; and~~

~~(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.~~

~~FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:~~

~~(a) does not bear proper features that have been incorporated into the ballot paper;~~

~~(b) voting for more candidates than the voter is entitled to;~~

~~(c) writing or mark by which voter could be identified; and~~

~~(d) unmarked or rejected because of uncertainty,~~

~~and, where applicable, each heading must record the number of ballot papers rejected in part.~~

~~FPP44.6 Any text voting record:~~

~~(a) on which votes are given for more candidates than the voter is entitled to vote,~~

~~(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or~~

~~(c) which is unmarked or rejected because of uncertainty,~~

~~shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.~~

~~FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.~~

~~FPP44.8 A text voting record on which a vote is marked:~~

~~(a) otherwise than by means of a clear mark; or~~

~~(b) by more than one mark,~~

~~is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.~~

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted; and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to;

(b) writing or mark by which voter could be identified; and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub- parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b); or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate;

(b) add that value to the previous total of votes recorded for each candidate and record the new total;

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non- transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred; and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given; and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes; or

(ii) the total transfer value of votes transferred to each candidate;

(b) add that total to the previous total of votes recorded for each candidate and record the new total;

(c) record the value of non-transferable votes and add that value to

the previous non-transferable votes total; and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust; or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not);

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5; and

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution

pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust; or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not;

(b) any transfer of votes;

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;

(d) the order in which the successful candidates were elected;

(e) the number of rejected ballot papers under each of the headings in rule STV44.1; and

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation; and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records;

(b) the ballot papers and text voting records endorsed with "rejected in part";

(c) the rejected ballot papers and text voting records; and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the list of spoilt ballot papers and the list of spoilt text message votes;

(c) the list of lost ballot documents; and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the corporation to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll;

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:

(i) any rejected ballot papers, including ballot papers rejected in part;

(ii) any rejected text voting records, including text voting records rejected in part;

(iii) any disqualified documents, or the list of disqualified

documents;

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records; or

(v) the list of eligible voters; or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;

(b) time;

(c) place and mode of inspection; and

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent; and

(b) in making the documents available for inspection,

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class; and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received;

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records; and

(c) ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the corporation to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses;

(b) travelling expenses, and expenses incurred while living away from home; and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates;

and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair;

(b) equivalent in size and content for all candidates;

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words;

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"); and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a

~~view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.~~

~~65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.~~

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

~~67. Secrecy~~

~~67.1 The following persons:~~

~~(a) the returning officer; and~~

~~(b) the returning officer's staff,~~

~~must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:~~

~~(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted;~~

~~(ii) the unique identifier on any ballot paper;~~

~~(iii) the voter ID number allocated to any voter; or~~

~~(iv) the candidate(s) for whom any member has voted.~~

~~67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.~~

~~67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.~~

~~68. Prohibition of disclosure of vote~~

~~68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.~~

~~69. Disqualification~~

~~69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:~~

~~(a) a member of the corporation;~~

~~(b) an employee of the corporation;~~

~~(c) a director of the corporation; or~~

~~(d) employed by or on behalf of a person who has been nominated for election.~~

~~**70. Delay in postal service through industrial action or unforeseen event**~~

~~70.1 If industrial action, or some other unforeseen event, results in a delay in:~~

~~(a) the delivery of the documents in rule 24; or~~

~~(b) the return of the ballot papers,~~

~~the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.~~

ANNEX 45 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Roles and responsibilities of the Council of Governors

1.1 The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with the Constitution:

1.1.1. to appoint, and if appropriate, to remove the Chair;
1.1.2. to appoint, and if appropriate, remove the other non-executive directors;
1.1.3. to decide the remuneration and allowances and conditions of office of the Chairman and other non-executive directors;
1.1.4. to approve the appointment of the Chief Executive;
1.1.5. to appoint, and if appropriate, remove the auditor;
1.1.6. receive the Trust's annual accounts, and any report of the auditor on them, and the annual report;
1.1.7. in preparing the Trust's annual plan, the Board of Directors must have regard to the views of the Council of Governors;
1.1.8. to decide whether the Trust's private patient work would significantly interfere with the Foundation Trust's principal purpose, which is to provide goods and services for the health service in England, or performing the Foundation Trust's other functions;
1.1.9. to approve any proposed increase in non-NHS income of 5% of the Trust's total income in any one financial year;
1.1.10. to hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors;
1.1.11. to represent the interests of the members of the Trust as a whole and the interests of the public;
1.1.12. to act in the best interests of the Trust and to adhere to its values and code of conduct;
1.1.13. to regularly feedback information about the Trust, its vision and its performance to the constituencies and stakeholder organisations that either elected them or appointed them;
1.1.14. to prepare and review on an annual basis the Trust's membership strategy and its policy for the composition of the Council of Governors and of the non-executive directors; and
1.1.15. when appropriate, to make recommendations for the revision of this Constitution.

2. Appointed Governors

Local Authority Governors

2.1 The Chairman, having consulted with Devon County Council, South Hams District Council, Teignbridge District Council and Torbay Unitary Authority,

or any successor local authority for an area which includes the whole or part of an area forming part of the South Hams and Plymouth, Torbay or Teignbridge Public Constituency~~ies,~~ is to adopt a process for agreeing the appointment of one (1) Local Authority Governor from each of those local authorities.

Partnership Governors

2.2 The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Chairman.

General Provisions

2.3 Appointed Governors:

2.3.1 appointed Governors shall normally hold office for a period of three (3) years commencing on the date such appointment is to have effect;

2.3.2 appointed Governors are eligible for re-appointment at the end of that period; and

2.3.3 appointed Governors may not where re-appointed hold office for longer than nine (9) consecutive years, and shall not be eligible for re-appointment if they have already held office for more than six (6) consecutive years. One year is consecutive with another unless there is a period of not less than one year between them.

2.4 Additional Roles and Responsibilities of Appointed Governors Subject always to the overriding principle that the Governors' first responsibility is to the Council of Governors and the Trust:

2.4.1 the roles and responsibilities of the Appointed Governors which are to be carried out in accordance with the Constitution include:

2.4.1.1 to further the relationship between the organisation that the Appointed Governors represent and the Trust;

2.4.1.2 to bring to the Council of Governors a greater understanding of the organisation that the Appointed Governors represents;

2.4.1.3 to speak with authority for the organisation they represent and be able to explain its policies; and

2.4.1.4 to represent the Trust to the organisation they represent.

3. Eligibility to be a Governor

3.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

3.1.1 they are a director of the Trust, or a Governor or director or employee of another NHS body as defined in section ~~28(6)~~275 of the 2006 Act (unless they are an appointed Governor of the Trust appointed by the NHS body for which they are ~~a Governor~~an employee or director);

3.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors (including the Chair) of the Trust;

3.1.3 being a member of the Public Constituency they refuse to sign a declaration in the form specified by the Secretary, of particulars of their

qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

3.1.4 they are a vexatious complainant within the meaning of paragraph 1.1.2 in Appendix 9;

3.1.5 on the basis of disclosures obtained through an application to the Disclosure Barring Service, they are not considered suitable by the Chairman on the basis of advice from the Trusts' director responsible for human resources;

3.1.6 They have not within the preceding two (2) years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment within a NHS Body;

3.1.7 they are a person whose tenure of office as the Chair or as a member or director of a NHS Body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of pecuniary interests;

3.1.8 they are a person who has had his or her name removed or been suspended from any list (including any performers list maintained by a clinical commissioning group) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not had subsequently had his or her name included in such list or had his or her suspension lifted or qualification reinstated;

3.1.9 they are incapable by reason of mental disorder, illness or injury of carrying out their functions as a Governor and it is anticipated that such incapacity will continue for a period of six (6) months or the remainder of the Governor's tenure of office;

3.1.10 they have within the preceding five (5) years been:

3.1.10.1 made subject to a Hospital Order under section 37 of the Mental Health Act (MHA) whether or not subject to restriction under section 41;

3.1.10.2 made subject to restrictions under section 41;

3.1.10.3 made subject to a transfer direction under the Criminal Procedure (insanity) Act 1964 as amended; and/or

3.1.11 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation; or

3.1.12 they have been excluded from the Trust's premises on the grounds of having been violent and/or abusive towards staff, patients and/or visitors or are subject to an anti-social behaviour order; or

~~3.1.12~~3.1.13 being a Staff Governor and/or member of the Staff Constituency they have a current and unexpired written warning which has been imposed following disciplinary action by the Trust. Spent disciplinary warnings will not preclude eligibility to be a Governor. If a Staff Governor is suspended from duties for any reason they will also be suspended as a Staff Governor for the duration of their suspension. Whilst a Staff Governor is under suspension, the Staff Governor cannot attend meetings of the Council of Governors, but missing any meetings of the Council of Governors will not count as failure to attend for the purposes of paragraph 4.1.3 of this Annex 5. For the avoidance of doubt, a member will not be precluded from eligibility as a Governor by reason of their suspension or as the subject of an ongoing disciplinary

procedure and/or fact finding investigation.

4. Termination of office and removal of Governors

4.1 A person holding office as a Governor shall immediately cease to do so if:

4.1.1 subject to paragraph 4.7 they resign by notice in writing to the Secretary;

4.1.2 they are under sixteen (16) years of age;

4.1.3 they fail to attend two (2) consecutive meetings, unless the Chairman, in consultation with the Council of Governors, is satisfied that:

4.1.3.1 the absences are due to reasonable causes; and

4.1.3.2 they will be able to start attending meetings of the Council of Governors again within such a period as is considered reasonable.

4.1.4 in the case of an elected Governor, they cease to be a member of the Constituency or class or area of the Constituency by which they were elected, which for the avoidance of doubt, includes in respect of a Public Governor a Governor moving their principal residence from one area within the Public Constituency to another or they are an elected member of a Devon County Council, South Hams District Council, Teignbridge District Council of Torbay Unitary Authority;

4.1.5 in the case of an Appointed Governor, the appointing organisation terminates the appointment;

4.1.6 they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

4.1.7 they have failed to sign and deliver to the Secretary a statement in the from required by the Secretary confirming acceptance of the code of conduct for Governors;

4.1.8 they have failed to sign and deliver a letter of acceptance in the form required by the Secretary, and/or it becomes apparent that any information provided by the person in respect of their eligibility to be a Governor or such letter of acceptance is or becomes inaccurate;

4.1.9 they are removed from the Council of Governors under the following provision:

4.1.9.1 a Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting on the grounds that he or she has committed a serious breach of the code of conduct for Governors, or he or she has acted in a manner detrimental to the interests of the Trust, and the Council of Governors consider that it is not in the best interests of the Trust for him or her to continue as a Governor. The Governor concerned may make representation on his or her own behalf to the Council of Governors.

4.1.10 a declaration is made pursuant to paragraph 4.4.5 below.

4.2 Each Governor shall be responsible for ensuring that they are eligible to become or continue as a Governor of the Trust.

4.3 If a Governor has been disqualified pursuant to paragraphs 4.1.2, 4.1.5 or 4.1.6 they shall only be eligible for re-election after a period of three (3) years.

4.4 Without prejudice to paragraph 4.2 of this Appendix 5:

4.4.1 where the Trust is on notice that a Governor may be disqualified from membership in accordance with this Constitution, the Secretary shall carry out all reasonable enquiries to determine whether or not the Governor in question is so eligible;

4.4.2 the Secretary, following their enquiries pursuant to paragraph 4.4.1 above, if, satisfied that the person may be so disqualified, shall give notice in writing to that person that the Trust proposes to declare the person disqualified;

4.4.3 in the notice sent by the Secretary pursuant to paragraphs 4.4.2 above, the Secretary shall specify the grounds on which it appears to them that the person is disqualified and give that person a period of at least 14 but no more than 28 days in which to make representations, orally or in writing, on the proposed disqualification;

4.4.4 Any representations pursuant to paragraph 4.4.3 above shall be made to, and considered by, a committee of the Directors, which in this case shall determine the proposal; and

4.4.5 if no representations pursuant to paragraph 4.4.4 above are received within the specified time or the committee of Directors upholds the proposal to disqualify the Governor having heard representations, the Secretary shall immediately declare that the person in question is disqualified and notify him or her in writing to that effect. On such declaration that person's tenure of office shall be terminated and he or she shall cease to act as a Governor.

4.5 If a Governor is aggrieved at his or her disqualification under paragraph 4.4, then s/he may apply in writing within 7 days (time of the essence) to the Secretary for the decision to be referred to an independent assessor. The independent assessor will then consider the evidence and conclude whether the proposed removal is reasonable or otherwise. On receipt of an application the Secretary and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. If they fail to agree on an independent assessor within 21 days of the date upon which the application is received, then the Trust Secretary shall request the Centre for Effective Dispute Resolution to nominate the independent assessor. The independent assessor's decision will be binding and conclusive on the parties.

4.6 Pending a final decision to be made in accordance with the provisions in paragraphs 4.4 and/or 4.5, the Chair or (following its appointment) the committee of Directors may in his, her or their absolute discretion suspend a Governor.

4.7 Pending a final decision to be made in accordance with the provisions in paragraphs 4.4 and/or 4.5, a Governor may not resign without the agreement of the Chair or (following its appointment) the committee of Directors if the Secretary has given notice in writing to that Governor under paragraph 4.4.2 that the Trust proposes to declare the Governor disqualified.

5. <u>Vacancies amongst Governors</u>

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

5.1.1 where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of that term of office of the Governor who is being replaced; or

5.1.2 where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

5.1.2.1 to call an election to fill the seat at the next annual election for the remainder of the terms of office of the Governor who is being replaced; or

5.1.2.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and be subject to election.

6. Expenses and Remuneration of Governors

6.1 The Trust may reimburse Governors for travelling and other costs and expenses incurred in carrying out their duties as the Board of Directors decides.

6.2 The Trust may at their discretion decide to reimburse the cost and expense of a Governor's carer arrangements necessarily and reasonably incurred in such Governor carrying out their duties as the Board of Directors decides.

6.3 In respect of a Staff Governor who is an employee of the Trust, the Board of Directors shall seek to facilitate such employee's reasonable participation as a Staff Governor during normal working hours to the extent reasonably necessary for the performance of their duties as a Staff Governor (including reasonable time off from his or her contracted duties) and shall not make any corresponding deduction from salary.

6.4 Governors are not to receive remuneration from the Trust otherwise than as set out in paragraphs 6.1 and/or 6.2 and/or 6.3 above of this Appendix 5.

7. Governors' Code of Conduct

7.1 The Trust from time to time publish a Governors' code of conduct and each Governor shall be required to follow and observe such code of conduct's provisions.

ANNEX 56 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. Meetings of the Council of Governors

1.1 The Council of Governors is to meet a minimum of four (4) times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen (14) days' written notice of the date and place of every meeting of the Council of Governor to all Governors. Notice of the Council of Governor's meetings will be made public by whatever communications method the Trust determines.

1.2 Meetings of the Council of Governors may be called by the Secretary, or by the Chair.

1.3 Meetings of the Council of Governors may be called by ten (10) Governors, which shall include at least one (1) elected Governor and one (1) appointed Governor, who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request.

1.4 The Secretary shall call a meeting on at least seven (7) but no more than twenty-eight (28) days' notice.

1.5 If the Secretary fails to call such a meeting following notice pursuant to paragraph 1.3 above then the Chair of ten (10) Governors, which ever is the case, shall call such a meeting.

1.6 At least one-third of Governors shall form quorum for the Council of Governors.

1.7 Meetings of the Council of Governors' shall be chaired by the Trust Chair. On matters concerning the succession of the Chair, the Senior Independent Director will preside.

1.8 The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the auditor or other advisers to attend a meeting of the Council of Governors.

1.9 Any Governor who is unable to attend the Council of Governors meeting should advise the Secretary in advance of the meeting.

1.10 Any Governor who is not able to be present in person may participate in a

Council of Governor's meeting by means of conference telephone or any other such electronic means, which allows all participating in the meeting to hear each other. A Governor so participating shall be deemed to be present in person at such meeting and shall be entitled to vote and counted in the quorum. Such a Council of Governor's meeting shall be deemed to take place where the largest group of those participating is assembled, or, if there is no such group, where the Chair is located.

1.11 Subject to the Constitution and the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

1.12 Not used

1.13 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. The Council of Governors may appoint Governors and may invite directors and other persons to serve on such committees. The Council of Governors may, through the Secretary, request that external advisors assist them to any committee they appoint in carrying out its duties.

1.14 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid notwithstanding any vacancy or any defect in the calling of the meeting, or the election or appointment of the Governors attending the meeting.

1.15 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for the whole or part of such meeting in the following circumstances:

1.15.1 where the Council of Governors by resolution decides for reasons of commercial confidentiality for other special reasons arising from the business of the meeting; or

1.15.2 wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

1.16 The Chairman may exclude a member of the public if they are interfering with or preventing the proper conduct of the meeting.

Proposing Council of Governors' motions

1.17 Questions on notice are defined as questions from Governors about matters which are directly in relation to matters over which the Council of Governors had powers or duties, or which affect the services provided by

the Trust.

1.18 A Governor may ask a question which is not related to items on the forthcoming Council of Governors' agenda.

1.19 An answer may take the form of: a direct oral answer; where the information is in a publication of the Trust or other published work by reference to that publication; where the reply cannot be conveniently be given orally in the form of a written answer circulated later to the questioner and the Council of Governors; or by brief oral answer supplemented by a written answer circulated later to the questioner and the Council of Governors.

1.20 Approval to speak at Council of Governors' meetings will be given by the Chair. Unless in the opinion of the Chair it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature, complexity and importance, no proposal speech, nor any reply, may exceed three minutes. in the interests of time, the Chair may limit the number of replies which are heard.

1.21 A person who has spoken on a motion may not speak again whilst it is the subject of debate, except in exercise of right of reply, on a point of order, or, at the discretion of the Chair.

1.22 Supplementary questions for clarification may be asked at the discretion of the Chair.

1.23 Motions may only be submitted by Governors and must be received by the Secretary in writing at least fourteen (14) days before the meeting date, together with any relevant supporting paper. Except for motions which can be moved without notice under 1.23, written notice of every motion signed or transmitted by at least two (2) Governors, is required. The Secretary shall acknowledge such motions.

1.24 Urgent motions may be submitted before the commencement of meetings of the Council of Governors, provided that the motions are signed or transmitted by at least two (2) Governors. Consideration of urgent motions shall be at the discretion of the Chair.

1.25 The following motions may be moved without notice: accuracy of the minutes; change the order of business in the agenda; refer something to an appropriate body or individual; appoint a working group arising from an item on the agenda; receive reports or adopt recommendations made by the Board of Directors; withdraw a motion; amend a motion (without

substantially altering the intention of the motion); proceed to the next business; that the question now be put; adjourn a debate; adjourn a meeting; suspend a Council of Governors procedure rule (for the duration of the meeting); exclude the public and press; give the consent of the Council of Governors where its consent is required by the Constitution; or, not hear further a Governor or to exclude them from the meeting.

Proposing Council of Governors' Written Resolutions

1.26 The Secretary, the Chair, or ten (10) Governors, including one Elected Governor and one Appointed Governor, who give written notice to the Secretary specifying the business to be carried out may propose a Council of Governors' written resolution.

1.27 The following may not be passed as a written resolution: the removal of a Non-Executive Director or Chair; removal of the auditor; or, approval of a significant transaction.

1.28 A Council of Governors' written resolution is proposed by giving written notice of the proposed resolution to each Governor. Notice by post, delivery in person, fax or email shall constitute written notice.

1.29 Notice of a proposed Council of Governors written resolution must indicate:

1.29.1 the proposed resolution;
1.29.2 how to signify agreement to the resolution; and
1.29.3 the date by which it is proposed that the Council of Governors should adopt it. A proposed written resolution shall lapse if not adopted by the 28th day from circulation.

1.30 References in this paragraph to eligible Governors are to members of the Council of Governors who would have been entitled to vote on the matter had it been proposed at a meeting of the Council of Governors.

1.31 A decision may not be taken in accordance with this paragraph if the eligible governors would not have formed a quorum at such a meeting.

1.32 The resolution is deemed to have been passed when the required majority (simple majority, or 75% majority if a special resolution) as appropriate of eligible Governors have signed their agreement to it.

1.33 Where decisions of the Council of Governors are taken by means other than at a face-to-face meeting or by written resolution, such decisions shall be recorded by the Secretary in permanent written form.

2. Disclosure of interests

2.1 Members of the Council of Governor's shall disclose to the Council of Governor's any material interests as defined below held by a Governor, and shall withdraw from the meeting and play no part in the relevant discussion or decision and shall not vote on the issue (and if advertently they do remain and vote, their vote shall not be counted).

2.2 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

2.3 Subject to the exceptions below, a material interest in a matter is where a Governor:

2.3.1 holds any directorship, including non-executive directorship, (with the exception of dormant companies) of a company;
2.3.2 holds any interest or position in any firm or company or business;
2.3.3 has any interest in an organisation providing health and social care services to the National Health Service; or
2.3.4 holds any position of authority in a charity or voluntary organisation in the field of health and social care;

and such organisation is, in connection with the matter, trading with the Trust or entering into a financial arrangement with the Trust, or is likely to be considered as a potential contractor to the Trust.

2.4 The exceptions which shall not be treated as material interests are as follows:

2.4.1 shares held in any company where the value of those securities does not exceed £25,000 or the number of shares held does not exceed 5% of the total number of issued shares in a company whose shares are listed on any public exchange;
2.4.2 an employment contract with the Trust held by a Staff Governor;
2.4.3 an employment contract with a local authority held by a Local Authority Governor;
2.4.4 an employment contract with a partnership organisation held by a Partnership Governor; or
2.4.5 any travelling or other expenses or allowances payable to a Governor.

3. Declaration

An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the from specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented rom being a member of the Council of Governors. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors.

4. Council of Governors Committees, Sub-Committees and Groups

4.1 The Council of Governors shall establish a nominations committee for the purpose of discharging its duties in accordance with the 2006 Act and the NHS Foundation Trust Code of Governance. The nominations committee will decide the remuneration and allowances and other terms and conditions of office of the Chairman and other non-executive directors.

4.2 The Council of Governors may appoint additional committees consisting of its members to assist it in carrying out its functions. A committee appointed under this paragraph may also appoint a sub-committee.

ANNEX ~~67~~ – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

The Standing Orders for the Board of Directors must provide for:

1.1 Provision for the composition, membership, tenure and role of members of the Board of Directors.

1.2 Provision for the conduct of meetings including:

1.2.1 Notices of motions, petitions, the withdrawal of motions and motions to rescind resolutions;
1.2.2 Voting, which may not provide for voting otherwise than on the basis of one vote for each Director apart from the Chair of the meeting;
1.2.3 Provision for proxies;
1.2.4 Chairing the meeting in the absence of the Trust Chair;
1.2.5 Powers of the Chair to determine the conduct of the meeting;
1.2.6 Circumstances where persons other than Directors may be allowed to speak at meetings;
1.2.7 Quorum;
1.2.8 Provision for a record of attendance and the requirement for minutes of the meetings to be kept;
1.2.9 Provision for the approval of decisions without meetings;
1.2.10 Provision for meetings to be held using telephone or electronic means;
1.2.11 Provision for the establishment of committees, sub-committees and working groups which must include; an Audit Committee comprising Non-Executive Directors, an Executive Nominations and Remuneration Committee, comprising Non-Executive Directors and the Chief Executive; and a Charitable Funds Committee;
1.2.12 Provision for the appointment of Chair, Non-Executive Directors, Executive Directors and Secretary, and the appointment of Vice-Chair and Senior Independent Director;
1.2.13 Provision for requiring the declarations of interests and providing for the conduct of Directors when an interest is material;
1.2.14 Provision requiring the adherence to the Nolan Principles and NHS Standard of Business Conduct as published from time to time;
1.2.15 Provisions governing the procurement of works, goods and services, and tendering and contract procedures;
1.2.16 Provision regarding the use of the seal of the Foundation Trust and the execution of documents; and
1.2.17 Provision for the exercise of functions by delegation, including financial instructions.

1.3 This appendix 7 is to be read in conjunction with the Foundation Trust's standing orders which contain additional provisions.

ANNEX 78 – ANNUAL MEMBERS MEETING

1.1 The Trust shall hold a members' meeting for all members (called the Annual Members Meeting) within six months of the end of the financial year of the Trust.

1.2 Any members' meeting other than the Annual Members' Meeting shall be called a 'Special Members Meeting'.

1.3 Both Annual Members' Meetings and Special Members' Meetings shall be open to all members of the Trust, members of the Council of Governors and members of the Board od Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisor's whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

1.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.

1.5 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the Agenda shall be considered at any members' meeting.

1.6 The Board of Directors (or at least one (1) member of the Board of Directors) shall present to the members of the Annual Members' Meeting:

1.6.1 the annual accounts;
1.6.2 any report of the auditor on them;
1.6.3 the annual report;
1.6.4 a report on steps taken to secure that (taken as a whole) the actual membership of the Trust is representative of those eligible for such membership;
1.6.5 the progress of the membership plan; and
1.6.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required.

1.7 The Trust shall give notice of all members' meetings:

1.7.1 by notice prominently displayed at the Trust's headquarters;
1.7.2 by notice on the Trust's website;

1.7.3 by notice communicated by email to the Trust members; and

1.7.4 to the Council of Governors, Board of Directors and the Trust's Auditors, stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).

1.8 Accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.9 The Chair or in his or her absence, the Deputy Chair, shall preside at all members' meetings of the Trust. If neither the Chair not the Deputy Chair is present, the Governors present shall elect one of the Non-Executive Directors to act as Chair. If no Non-Executive Director is present, the Governors present shall elect one of their number to act as the meeting Chair. In no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.

1.10 The quorum for a members' meeting shall be twenty (20) members present and entitled to vote. If a quorum is not present within thirty (30) minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven (7) days until such time as the Board of Directors determine.

1.11 No such meeting shall become incompetent to transact business by lack of a quorum arising after the chair has been taken.

1.12 The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.

1.13 A resolution put to the vote at a members' meeting shall be decided on a show of hands, including without limitation a vote on an amendment to the Constitution in relation to the powers and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

1.14 Every member registered who is present shall have one vote. No proxies will be admissible.

1.15 The Trust's Auditor shall act as scrutineers in event of any voting.

1.16 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.17 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date, and/or place.

1.18 In the case of a members' meeting is adjourned or postponed for fourteen (14) days or more, at least seven (7) working days' notice shall be given, specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

1.19 The Board of Directors may make any such arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.

1.20 Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. No proposal, speech or any reply may exceed three (3) minutes unless the Chair directs otherwise. In the interests of time, the Chair may, in his or her absolute discretion, limit the number of replies, questions or speeches which are heard at any one members' meeting.

1.21 A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply or (ii) on a point of order, or (iii) at the Chair's discretion.

1.22 The ruling of the chair on any matter of procedure or a point of order shall be final.

1.23 The proceeding of members' meetings shall not be recorded and no person present shall make a recording of the meetings, other than in written

format.

1.24 The Board of Directors shall cause minutes to be made and kept, in writing, of all proceedings at members' meetings.

1.25 The minutes of members' meetings shall be presented to the next meeting of the Council of Governors.

1.26 The Board of Directors may make any arrangements and impose any restriction it considers necessary and/or appropriate to ensure the security of a members' meeting.

1.27 Any member who is not able to be present in person may participate in an members' meeting by means of conference telephone or any other such electronic means, which allows all participating in the meeting to hear each other. A member so participating shall be deemed to be present in person at such meeting and shall be entitled to vote and be counted in the quorum. Such a members' meeting shall be deemed to take place where the largest group of those participating is assembled, or if there is no such group, where the Chair is located.

ANNEX 89 – FURTHER PROVISIONS

1. Restriction on Membership

1.1 An individual who:

1.1.1 has threatened, harassed, harmed or abused staff, patients and/or visitors of the Trust; or

1.1.2 has been a vexatious complainant. For the purposes of this paragraph a vexatious complainant is an individual who is found by the Trust (applying the relevant policy), to have abused or used inappropriately the Trust's complaints procedure.

2. Termination of Membership

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this constitution;

2.1.4 they cease to be entitled under this constitution to be a member of the Public Constituency (if a member of the Public Constituency) or of any of the classes of the Staff Constituency (if a member of the Staff Constituency); and/or

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors they fail to demonstrate that they wish to continue as a member of the Trust.

2.2 A member may be expelled by a resolution approved by not less than two thirds of the Governors present and voting at the meeting of the Council of Governors. The following procedure is to be adopted:

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 subject to the disputes procedure set out in paragraph 3 dismiss the complaint and take no further action;

2.2.2.2 for a period not exceeding twelve (12) months suspend the rights of the member complained of to attend members meetings and vote under this constitution; or

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the company must be sent to the member complained of not less than one (1) month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At a meeting of the Council of Governors, the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting of the Council of Governors without due cause the meeting may proceed in their absence.

2.2.6 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting of the Council of Governors that the resolution to expel them is carried.

2.2.7 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governor present and voting at a meeting of the Council of Governors.

2.2.8 Pending a final decision to terminate membership in accordance with the provisions in this paragraph 2.2, the Chair may in his, her or their absolute discretion suspend a member.

3. Dispute Resolution Procedure

3.1 Every unresolved dispute which arises out of this Constitution between the Trust and:

3.1.1 a member;
3.1.2 any aggrieved person who has ceased to be a member within the six (6) months prior to the date of the dispute;
3.1.3 any person bringing a claim under this Constitution; or
3.1.4 an office-holder of the Trust;

shall first be referred to the Secretary who shall decide on the point in issue.

3.2 If the member or applicant (as the case may be) is aggrieved at the decision of the Secretary he or she may appeal in writing within 14 Clear Days of the Secretary's decision to the Council of Governor whose decision shall be final.

3.3 In the event of a dispute between the Council of Governors and the Board of Directors:

3.3.1 In the first instance, the Chair, on the advice of the Secretary, and such

other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

3.3.2 If the Chair is unable to resolve the dispute, the Chair shall refer the dispute to the Secretary who shall appoint a joint special committee of the Board of Directors and the Council of Governors, comprising equal numbers of Directors and Governors, to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

3.3.3 If the recommendations (if any) of the joint special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

3.4 In the event of any dispute in relation to this Constitution that concerns anything other than membership, or disputes between the Council of Governors and the Board of Directors, the dispute shall be referred to the Chair who shall decide on the point of issue.

3.5 If the member or complainant (as the case may be) is aggrieved at the decision of the Chair he or she may appeal in writing 14 Clear Days of the Chair's decision to the Board of Directors, whose decision shall be final.

4. Indemnity

4.1 Members of the Council of Governors, the Board of Directors and the Secretary, who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution, or purported execution, of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust.

4.2 The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors, the Board of Directors and the Secretary.

4.3 The Foundation Trust may take out insurance, either through the NHS Litigation Authority or otherwise, in respect of directors and officers liability arising by reason of the Foundation Trust acting as a corporate trustee of an NHS charity.

5 Appointment of Lead Governor

The Council of Governors may appoint annually one of its' Public Governors to be Lead Governor. The Governor appointed shall undertake

the duties as stated in the NHS Foundation Trust Code of Governance, and such other duties as may be assigned from time to time.