# Public
# Board of Directors

**Date:** Wednesday 28th June 2023

**Time:** 11.30 am – 2.00 pm

The Boardroom
Hengrave House
Lowes Bridge
TQ2 7AA

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# TSDFT Public Board of Directors

28/06/2023 11:30

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# OUR STRATEGY AND PURPOSE

**Our Purpose (what is our role in society?):**

- Our purpose is to support the people of Torbay and South Devon to live well

**Our Goals (how do we measure our success?):**

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

**Our Priorities (what do we need to focus on to achieve our goals):**

- More personalised and preventative care: 'What matters to you matters to us'
- Reduce inequity and build a healthy 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

**Our Objectives:**

- Quality and Patient Experience
- People
- Financial Sustainability
- Estates
- Operations and Performance Standards
- Digital and Cyber Resilience
- Building a Brighter Future
- Transformations and Partnerships
- Integrated Care System
- Green Plan/Environmental, Social and Governance

**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST PUBLIC BOARD OF DIRECTORS MEETING HELD IN THE BOARDROOM, HENAGRAVE HOUSE AT 12 NOON ON 31 MAY 2023**

| | | |
|---|---|---|
| Present: | Sir Richard Ibbotson | Chairman |
| | Mrs L Davenport | Chief Executive |
| | Dr P Aitken | Associate Non-Executive Director |
| | Professor C Balch | Non-Executive Director |
| | Mr R Crompton | Non-Executive Director/Vice Chairman |
| | Mr I Currie | Chief Medical Officer |
| | Ms A Jones | Director of Transformation and Partnerships |
| | Ms D Kelly | Chief Nurse |
| | Dr K Lissett | Interim Medical Director |
| | Mrs E Long | Director of Corporate Governance and Trust Secretary (non-voting Board Member) Left for agenda item 097/05/23 |
| | Mrs J Lyttle | Non-Executive Director |
| | Mrs V Matthews | Non-Executive Director |
| | Mr D Stacey | Deputy Chief Executive Officer and Chief Finance Officer |
| | Mr R Sutton | Non-Executive Director |
| | Ms S Walker-McAllister | Non-Executive Director |
| | Dr J Watson | Health and Care Strategic Director (non-voting Board Member) |
| | Dr M Westwood | Chief People Officer |
| In attendance: | Mrs J Bassett | Head of Midwifery (Agenda item no. 099/05/23) |
| | Mr J Broad | South West Integrated Personalised Care |
| | Mrs S Byrne | Board Secretary |
| | Mrs S Burns | Freedom to Speak Up Guardian (Agenda item no. 101/05/23) |
| | Dr J Harris* | Associate Director of Communications and Partnerships |
| | Mr J Hawkins* | Governor |
| | Mr A Postlethwaite | Governor |
| | Miss H Rae | Graduate management trainee |
| | Mrs J Thomas* | Governor |
| | Mr L Thomas* | Governor |

* via Microsoft Teams

085/05/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

**Preliminary Matters**

086/05/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Mr Paul Richards.

087/05/23 **Declarations of Interest**

No declarations of interest were received.

088/05/23 **Board Corporate Objectives**

**The Board received and noted the Board Corporate Objectives.**

**For Approval**

089/05/23 **Unconfirmed Minutes of the Meeting held on the and outstanding action**

The Board approved the minutes of the meeting held on 26 April 2023 pending the following amendment:

- Mrs V Matthews was to be noted as in attendance.

**The Board approved the minutes of the meeting held on**

**Consent Agenda (Pre-notified questions)**

090/05/23 **Committee Reports**

**The Board received and noted the Committee Reports.**

091/05/23 **Committee Annual Reports**

**The Board received and noted the Committee Annual Reports.**

**Reports from the Executive Directors (for noting)**

092/05/23 **Chief Operating Officer's Report - May 2023**

**The Board received and noted the Chief Operating Officer's Report of May 2023.**

093/05/23 **Workplace Team Strategic Performance Update**

**The Board received and noted the Workplace Team Strategic Performance Update.**

094/05/23 **Report of the Chairman**

The Chairman verbally briefed the Board on the following:

- With leadership from Mr Currie and Dr Westwood, the Trust have undertaken a pledge of allegiance to the Armed Forces covenant.
- Mr Peter Milford had been recently appointed at Lead Governor until May 2024.
- Mrs Jean Thomas and Mr Andrew Stilliard were thanked for their service as Lead Governor and Deputy Lead Governor for the past 12 months respectively.
- Cllr. Ged Vardy had been appointed as the new Governor for the South Hams.
- The Trust would sadly be losing the following Councillor Governors, Rose-Marie Rowe for South Hams District Council; Nicole Amil for Torbay Council; and Andrew McGregor for Teignbridge Council, he thanked them for their contribution.
- Norman McNamara started the Purple Angel Dementia Campaign 10 years ago at Torbay; and recently, ambassadors had been appointed in Malaysia. The Purple Angle Dementia Campaign therefore now had ambassadors in the United Kingdom, United States of America, Europe and Asia.

**The Board received and noted the report of the Chairman.**

095/05/23 **Chief Executive's Report**

Mrs Davenport briefed the Board on the following from the Chief Executive's Report, as circulated:

**New Hospital Plan:** The Trust had received confirmation it would be in the first tranche of the New Hospital Plan programme, with the scheme to be submitted in 2023 and progressed for delivery by 2030.

**CQC:** Ahead of the Trust's CQC Well Led inspection. The first two day core inspection of services took place on the 24 and 25 May 2023; a second core service

inspection was due to take place in the coming weeks. The Trust had received an initial feedback letter from the CQC and immediate actions were being focused on.

Ms Kelly explained the CQC Core service inspection focused on the following areas: Emergency Department; Acute Medical Unit; Outpatients; and Medical Services. The intention of the core service inspections ahead of the Well Led inspection was to triangulate data to clarify the level of 'floor to Board' support and oversight.

She noted her thanks to the CQC inspectors for supporting, listening and clearly drawing out the best from the teams they met with and highlighted to the Board how noticeably engaged the staff were with the inspectors, with staff highlighting the challenges but, providing assurance as to how they were supporting change.

The Board were informed the following points were highlighted from the inspection and the following plans were in place:

- Opportunities to strengthen clinical engagement and model across the Trust;
- The Environment, in particular in respect of privacy and dignity - a Privacy and Dignity campaign was to be launched this week;
- The Paediatric baby changing facilities had been improved; and
- Fire safety risks had been addressed.

Mrs Davenport confirmed the Trust would be building its improvement plan alongside the CQC inspection as staff engagement of Regain and Renew was being progressed; the Just Culture Survey was live; and Patient Safety Incident Report Framework (PSIRF) was being implemented.

The Chairman clarified the Trust's own self-assessment had highlighted improvements that could be made and would have been made regardless of a CQC visit.

**Healthwatch – Men's Health:** Healthwatch were making contact with local men about how healthcare providers engage with and listen to their service needs.

**Sarah Wollaston visit:** Mrs Sarah Wollaston, the Chair of Devon ICS, visited the Trust to shadow Becky Gardner, Occupational Therapist and Hospital Discharge Lead. Her aim was to understand how the Trust were supporting patients to return home safely. Mrs Wollaston was planning to spread the learning across the system.

**Our People Celebration Event the** Our People Celebration Event had enabled our people to showcase their great work; and it was well received by all those who were invited to attend and those who sponsored the event.

**Dartmouth Health and Well Being Centre:** The Dartmouth Health and Well Being Centre was officially opened on 9 May 2023 by Sir Richard Ibbotson and David Fursdon, HM Lord Lieutenant of Devon. The Trust had placed Dartmouth Hospital on the open market after the bid from Dartmouth Town Council failed to reach completion.

**New Endoscopy and Theatre Provision:** The Trust were preparing the site for a £4.99m building project to create a fourth endoscopy room and training facility; as well as the refurbishment of the current endoscopy rooms, this would enable the Trust to see more patient and improve their experience and outcomes.

**Deputy CEO and Chief Finance Officer:** After 10 years with the NHS, Mr Stacey, the Trust's Deputy CEO and Chief Finance Officer would be leaving the Trust at the end of July to join the University of Exeter as Chief Financial Officer and Executive Divisional Director of Finance.

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

**Safe Quality Care and Best Experience**

096/04/23 **Integrated Performance Report (IPR): Month 1 2022/23 (April 2023 data)**

Mr Currie presented the IPR for April 2023 data to the Board, as circulated. He highlighted the following points:

**Quality**

- No Never Events had been reported;
- One incident of severe harm had been verified and was reported on the national StEIS system;
- Two incidents of death were reported within the Trust.

**Operational performance**

- 22.5% of patients were admitted to the Stroke Ward within 4 hours, this is below the 90% target. This was primarily due to the inability to obtain stroke beds due to Infection Prevention Control measures.
- Infection Prevention Control bed closures had increased due patients testing positive for Covid19 or Flu on admission; and outbreaks of norovirus.
- No still births had been reported.
- The number of women to be reported as smoking at birth was 5.8% which was below the national average of 8.6% and was likely to be due to a specialist smoking cessation midwife being in post.
- The necessary performance level had been met for the Trust to be classified at Tier 2 due to a sustained period of improvements within cancer services.
- The Trust were continuing to reduce the 62 day cancer backlog.
- Orthopaedics had improved the length of stay times and increased capacity by utilising insourcing lists and the Nightingale.
- Ophthalmology waiting lists were decreasing by undertaking high volume, low complexity lists.
- Non admitted pathways remained challenged in particular, Ear Nose and Throat, Oral Surgery, Gynaecology and Urology.
- Significant pressure on the Urgent and Emergency Care Pathway remained.
- Ambulance handover times had improved.
- Focus remained on early and weekend discharges.
- The Trust reported a No Criteria to Reside (NCR) rate of 8%, which was the lowest within Devon ICS.

Mr Currie noted the Stroke Service was fragile and the increased visibility of the Integrated Stroke Delivery Network was important so plans could be developed as the need for collaborative working for the benefit of the population was recognised. With regard or stroke performance indicators, Ms Kelly brought to the Board's attention that although stroke patients may not always be allocated a bed on a

stroke ward, there was good evidence of access to the correct treatment whilst they are on other wards. Mrs Lyttle confirmed the Quality Assurance Committee would continue to review the stroke data.

Prof. Balch asked for confirmation that the Trust could meet the improved performance trajectory, within the context of the Devon improvement plan (SOF4 exit), within the required timescales. Ms Jones confirmed there was good progress being made with plans to accelerate and put in place change capacity resource with support from the Provider Acute Sustainability Programme.

Mrs Lyttle asked for further information on the challenged gynaecological position. Mr Scott explained an increased number of referrals had been seen and this had co-insided with Consultant sickness. Mr Currie highlighted that post the Ockenden Report Consultant Gynaecologists had seen an increase in demands on their job plans.

Dr Aitken raised that he was unable to triangulate the VTE performance data within the IPR. Dr Lissett confirmed the data was reviewed by the VTE Group and with the support of Ms Kelly from next month the IPR would ensure there was a triangulation of the data so trends could be identified by the Board. **ACTION: Dr Lissett**

**Workforce**

- The Trust's Sickness level had increased to 5.07%, above the 4% target.
- A Strategic Workforce Planner had been appointed to develop the medium to long term work force plans.
- Agency and back staff spend was under review by the Procurement Team.

Mrs Matthews highlighted that although the turnover metric presented as normal, it was still high and she proposed the People Committee needed to review the turnover data as this led to a loss of knowledge for the Trust. **ACTION: Mrs Matthews**

**Finance**

- There was a favourable expenditure of £0.42m however this included an unplanned cost pressure of £0.17m due to the bank and agency support required to support sickness and Industrial Action.
- Recurrent savings of £46.6m had been identified and would be managed through the PMO governance process.

Mr Stacey confirmed all budget holders had just received letters detailing their budget for financial year 2023/24 and whole time head count. Budget holders would be accountable for delivery but this was the opportunity for them to plan with the support of their Business Managers.

**The Board received and noted the Integrated Performance Report (IPR): Month 1 2022/23 (April 2023 data)**

097/05/23 **May 2023 Mortality Score Card**

Mr Currie highlighted the following points from the May 2023 Mortality Score Card, as circulated, to the Board:

- Accurate coding into a patient's pathway before a death was under review and a deep dive was awaited.
- The Medical Examiners were scrutinising a 100% of acute deaths and were reviewing community deaths too.
- A study had been undertaken in respect of mortality rates verses length of time a patient spent in the Emergency Department and would be presented to the Quality Assurance Committee in July.
- A number of hospitals had seen an increased Hospital Standardised Mortality Rate.
- A spike in deaths could be seen on the unadjusted mortality chart in December 2022, which was to be expected as it was within the winter.
- A structured review process was being undertaken in respect of Learning Disability deaths.

Dr Watson asked for more information on the robustness of Trust's learning from deaths process. Mr Currie confirmed 100% of acute deaths were reviewed by the Medical Examiners. There was a mortality and morbidity structure review process; and a learning incident review group with all learning from deaths being fed into ISU's or clinical teams depending on appropriateness. Ms Kelly explained that learning from avoidable deaths had led to a septismia improvement programme in the Emergency Department but recognised the need to ensure all learning was embedded.

Mr Crompton enquired as to the efficacy of the LeDER process undertaken in 2021/22. Mr Currie confirmed four Learning Disability deaths were reviewed outside of the formal process; five were undertaken in the last two years; and seven reviews thereafter. At present the Trust was waiting for the outcome of seven reviews. The output within the report was from the regional process but, the Trust do have GP advisors supporting. Mr Currie explained the new process came into force last month and confirmed the Trust were continuing to work with regional teams.

Mrs Davenport took an action to enquire whether the Trust could manage the reviews in a more timely way but, believed once the Patient Safety Incident Response Framework was embedded further information would be available to support investigations. **ACTION: Mrs Davenport**

Mr Currie thanked the Board for their engagement and summarised that learning from deaths was about training, education and culture.

**The Board received and noted the May 2023 Mortality Score Card.**

098/05/23 **Guardian of Safe Working Hours**

Dr Lissett presented the Guardian of Safe Working Hours Report, as circulated to the Board. She highlighted the following key themes:

- Surgical Juniors Dr's appeared to raise exception reports at the start of a rotation but, by the end of a rotation they were not being raised, as they had picked up speed.
- To support plans were in place to improve surgical staffing by August 2024.
- Dr Claire Blandford, Guardian of Safe Working Hours lead had undertaken work with those who sign off the exception forms to enable them to identify key themes within their teams.

**The Board received and noted the Guardian of Safe Working Hours Report.**

099/05/23 **Maternity Governance and Safety Report**

Ms Kelly, presented the Maternity Governance and Safety Report to the Board, as circulated.

- The quality of service had improved overall and the metrics showed good performance
- The overarching compliance position was 95%.
- The still birth rate tracked the national average of 4.2%.
- Compliance against CO2 monitoring remained good.
- The Trust had reported an improved smoking cessation rate.
- .

The Trust hosted the Professional Midwifery Advocate Conference this week with the conversation focused:

- On midwifery retention posts;
- Ockenden;
- Post East Kent; and
- Greater clinical intervention.

Mrs Bassett, informed the Board:

- The Trust had received a Clinical Negligence Scheme for Trusts position of 10/10.

Mrs Walker-McAllister confirmed, as the nominated NED for Maternity oversight, she had walked the department with Maria Mortimore.

Mr Crompton, highlighted within the Staff Survey 8.4% of the maternity department would recommend the Trust as a place to work. He asked why this may be. Mrs Bassett believed the response did not relate to the team but to the pay and conditions, she said this was a strong reason for the Trust to have retention midwife posts.

Mrs Davenport asked how the Maternity Department engaged with the people who used its services. She explained the Trust was part of the Maternity Voices partnership for the Local Maternity System which was key to engagement but, also engagement and learning was sought from feedback and complaints as well as inviting people to come in and reflect on their experiences to enable learning and improvement.

**The Board received and noted the Maternity Governance and Safety Report.**

100/05/23 **Health Inequality waiting list assessment of Trust position**

Ms Jones asked the Board to note the Health Inequality waiting list assessment of Trust position process, which had been presented to the Finance Performance and Digital Committee. She confirmed it had been prepared using Business Intelligence but although the data was available the reporting method was immature. However, going forward, there would be a regular data feed would look at inequalities.

Mr Crompton asked how health inequalities could be measured by the waiting lists. Ms Jones explained health inequalities data was assessed by particular characteristics and waiting times. However, Prof. Balch challenged those in deprived areas may not seek help and therefore, not be on a waiting list. Ms Jones agreed but explained the date was behind the One Devon Data set; and this was about waiting list inequality as opposed to health inequalities.

**he Board received and noted the waiting list assessment of Trust position**

**Valuing our workforce**

101/05/23 **Our Leadership and Management Framework: A compassionate Leadership Approach and Management Development Programme**

Dr Westwood presented the Our Leadership and Management Framework: A compassionate Leadership Approach and Management Development Programme, as circulated, which had been co-designed with a focus on culture. She highlighted the focus would be on the following phrases:

- We include;
- We listen;
- We act.

To enable the programme there would be a change in the name and focus of the People Directorate Departments to:

- Inclusivity and Organisational Culture Team;
- Human Resources Business Partners; and
- Educational and Workforce Development.

Following a detailed discussion, the following was noted:

- Over a 1000 leaders within the Trust would be required to undertake this training and need to be released from the workplace. However, funding had been identified. Training to be undertaken from September 2023 on a rolling programme to ensure joiners were captured.
- It would give managers confidence to manage staff and act.
- The programme would be piloted on Care Group Directors and Matrons.
- The programme was aligned to the people element of the Trust strategy.
- The Just Learning Culture spoke to both the Freedom to Speak Up Guardian work and the Patient Safety Incident Response Framework (PSIRF).

- The workforce development budget was currently funded by Health Education England and consideration needed to be given to how development for the non-clinical workforce was funded.
- Key Performance Indicators and measures were being scoped to facilitate the Board's oversight of this work.

Mrs Davenport highlighted the importance of the timing of this piece of work, especially as the new operational structure was about to be implemented and this would prepare people to work as leaders. Prof. Balch highlighted it would take time for the work to be embeded.

Dr Westwood confirmed from July Board would receive an Organisational Culture Update every quarter.

**The Board approved the Our Leadership Framework: A Compassionate Leadership Approach and Management Development Programme.**

101/05/23 **Freedom to Speak Up Guardian Report**

Dr Westwood, introduced, Mrs Burns, Freedom to Speak Up Guardian to the Board. She informed the Board:

- The number of cases she was handling had increased between October 2022 and April 2023.
- The issues escalated were in respect of bullying, harassment and instability in the workplace.
- The Work in Confidence anonymous platform had been well received and had enabled managers to own and resolve issues.
- She informed the Board the Equality, Diversity and Inclusion Guardian.
- She said there was a need for the Trust to be able to support international staff and their managers proactively but, at present, her role was reactive.

Mrs Matthews counselled there needed to be consequences and education for those who were repeatedly racist and misogynistic. She said how clearly this linked to strong leadership and management.

Mrs Kelly explained an immediate response and action plan needed to be developed to address issues that were continually unresolved and an accountability framework needed to be developed. **ACTION: Dr Westwood**

Mrs Davenport noted that the Trust needed to create the right environment for people to be able to feel that they can approach their line manager and have the confidence to speak up; with the Freedom to Speak Up Guardian being seen as the stop gap.

Mrs Burns reported how the Just Culture survey was enabling people to speak up.

It was agreed Dr Westwood would present proposals for additional resource to the Executive in the first instance to consider proposals for additional resource.
**ACTION: Dr Westwood**

Prof Balch asked if there were innovative ways in which the Freedom to Speak Up Guardian could be supported. Mrs Burns said unfortunately, at present, she was struggling to sign post people to the appropriate help.

**Well Led**

102/05/23 **Annual Self Certification Provider Licence Conditions**

Mrs Long presented the Annual Self Certification Provider Licence Conditions, as circulated, and previously noted by Audit Committee in April and circulated with their recommendation.

**The Board received and noted the Annual Self Certification Provider License Conditions.**

103/05/23 **CQC Registration Annual Assurance Report**

Ms Kelly presented the CQC Registration Annual Assurance Report, as circulated.

**The Board received and noted the CQC Registration Annual Assurance Report.**

104/05/23 **Board Assurance Framework and Corporate Risk Register**

Mrs Long presented the Board Assurance Framework and Corporate Risk Register.

The Board were asked to asked to approve the target risk score for the financial sustainability objective be reduced from 25 to 16.

**The Board approved the target risk score for the financial sustainability objective; received and noted the Board Assurance Framework and Corporate Risk Register.**

105/05/23 **NHS Standard Form Licence**

Mrs Long presented the NHS Standard Form License, as circulated, and previously discussed at April private board; as the previous meeting was held in a pre-election period it was noted in private Board in the first instance.

**The Board received and noted the NHS Standard Form License**

106/05/23 **Briefing: Hewitt Review**

Mrs Long presented the Briefing: Hewitt Review, as circulated, and previously discussed at April private board; as the previous meeting was held in a pre-election period it was noted in private Board in the first instance.

**The Board received and noted the Briefing: Hewitt Review**

082/04/23 **Compliance Issues**

083/04/23 **Any other business notified in advance**

084/04/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 28 June 2023

**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 |
|---|---|---|---|---|
| 172/09/22 | Ms Kelly will provide support to Lottie in progressing the Organ Donor Memorial in both suitable design and site location. | Ms Kelly | 26.10.22<br>Ms Kelly is progressing the Organ Donor Memorial. Designs are being finalised, funding was being secured and a space to place the memorial had been identified.<br>30.11.22<br>Ms Kelly confirmed two designs and a place for the memorial had been decided upon, the Trust were awaiting costings.<br>25.01.23<br>Ms Kelly confirmed the location of the memorial had been agreed but the Trust were awaiting a date for installation.<br>22.02.23<br>Ms Kelly confirmed Lottie was engaged with the Organ Donation memorial and site location.<br>29.03.23<br>Ms Kelly confirmed engagement with Lottie was ongoing.<br>26.04.23<br>Ms Kelly confirmed engagement with Lottie was ongoing. | 28.09.22 |

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| 061/03/23 | Ms Kelly and Mr Scott would discuss provision of exception reports for inclusion in the IPR report to highlight what actions were being taken to maintain safety and quality (when relevant – such as long ambulance waits/long waits for elective care) | Ms Kelly and Mr Scott | 26.04.23<br>Ms Kelly confirmed the quality metrics would be amended to create space for greater narrative. | 29.03.23 |
| 061/03/23 | Mr Stacey would ensure the IPR was revamped to make it easier to engage with and less demanding in terms of its volume and content, so that it could be used more frequently and effectively. | Mr Stacey | 26.04.23<br>The revamping of the IPR was in progress with, workforce and quality sections to follow. | 29.03.23 |
| 63/0/23 | Mr Currie to ensure an update on the outcomes of the local investigative work into the higher than anticipated HSMR is included in the next scheduled Mortality Score Care report | Mr Currie | 31.05.23<br>The report will come to the July Quality Assurance Committee and Board. | 29.03.23 |
| 071/04/23 | Ms Jones confirmed she would use the patient experience story as an example for partner organisations, in particular the Local Care Partnership, to draw on. | Mrs Jones | 31.05.23<br>Ms Jones confirmed she would be taking this to the June LCP meeting. Action closed | 26.04.23 |
| 074/04/23 | A Board to Board with Devon Partnership Trust would be arranged to ensure both Boards were briefed on the governance of Child Family Health Devon. | Mrs Davenport | 31.05.23<br>Mrs Davenport will report back to the Board with a date for the Board to Board with DPT. | 26.04.23 |
| 079/04/23 | The Board agreed the National Staff Survey would form part of a Board Development session; and Staff Engagement Updates would come regularly to the private Board. | Dr Westwood | | 26.04.23 |
| 096/05/23 | Dr Aitken raised that he was unable to triangulate the VTE performance data within the IPR. Dr Lissett confirmed the data was reviewed by the VTE Group and with the support of Ms Kelly from next month the IPR would ensure there was a triangulation of the data so trends could be identified by the Board. | Dr Lissett | | 31.05.23 |

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|---|---|---|---|---|
| 096/05/23 | Mrs Matthews proposed the People Committee reviewed the turnover data as this led to a loss of knowledge for the Trust. | Mrs Matthews | | 31.05.23 |
| 097/05/23 | Mrs Davenport said there was a need to ensure learning from deaths of those with Learning Disabilities was supported and took an action to enquire whether the Trust could manage the reviews in a timelier way. | Mrs Davenport | | 31.05.23 |
| 101/05/23 | Mrs Kelly explained an immediate response and action plan needed to be developed to address culture issues that were continually unresolved and an accountability framework needed to be developed. | Dr Westwood | | 31.05.23 |
| 101/05/23 | It was agreed Dr Westwood would present proposals for additional resource to support the Freedom to Speak Up Guardian role for the Executive Consider proposals for additional resource. | Dr Westwood | | 21.05.23 |

NHS
Torbay and South Devon
NHS Foundation Trust

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<tr><td>Report author</td><td colspan="3">Corporate Governance Manager</td></tr>
<tr><td>Report provenance</td><td colspan="3">n/a</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">The Board are asked to note the following summary of the Committee meetings held in the period.<br><br><u>Audit Committee: Chair - R Sutton</u><br>• No meetings held in June<br><br><u>Quality Assurance Committee: Chair (J Lyttle)</u><br>• 22 May 2023 (minutes yet to be published)<br><br><u>Charitable Funds Committee: Chair (J Lyttle)</u><br>• 14 June 2023 (minutes yet to be published)<br><br><u>Finance Performance and Digital Committee: Chair (R Crompton)</u><br>• 26 June 2023 (minutes yet to be published)<br><br><u>People Committee: Chair (Vikki Matthews)</u><br>• 26 June 2023 (minutes yet to be published)<br><br><u>Building a Brighter Future: Chair (C Balch)</u><br>• 21 June 2023 (minutes yet to be published)<br><br>Minutes of the meetings can be found within the Diligent online library:<br>Hyperlink: Diligent Boards: South Devon Health Information Services: Resource Center<br><br>Location: Diligent sign-in>Resource Centre>TSDFT Board and Sub-Committee Minutes<br><br>The Chair of each Committee is asked to escalate any pertinent matters verbally at the meeting, on an exception basis.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information<br>☐</td><td>To receive and note<br>☒</td><td>To approve<br>☐</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board asked to note:<br>• the Committee meetings held since the last meeting; and</td></tr>
</table>

| | |
|---|---|
| | • any exception reporting of Committee Chairs. |
| **Summary of key elements** | |
| **Strategic goals supported by this report** | |

| | | | |
|---|---|---|---|
| **Excellent population health and wellbeing** | | **Excellent experience receiving and providing care** | |
| **Excellent value and sustainability** | **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** | **X** | **Terms of Authorisation** | |
| **NHS England** | **X** | **Legislation** | **X** |
| **National policy/guidance** | **X** | | |

| **Report to the Board of Directors** | | | |
|---|---|---|---|
| **Report title**: Ethics Committee Annual Report 2022/23 | | | Meeting date: 28 June 2023 |
| **Report appendix** | Appendix 1 – Committee Annual Report | | |
| **Report sponsor** | Committee Chair | | |
| **Report author** | Director of Corporate Governance and Trust Secretary | | |
| **Report provenance** | | | |
| **Purpose of the report and key issues for consideration/decision** | The Ethnics Committee, in line with best practice, has prepared a report to the Committee that sets out how the Committee has met its Terms of Reference.<br><br>The purpose of this report is to provide assurance that the Ethics Committee has carried out its obligations in accordance with its Terms of Reference.<br><br>The Annual Report summarises the activities of the Committee for the financial year 2022/23. | | |
| **Action required (choose 1 only)** | **For information** ☐ | **To receive and note** ☒ | **To approve** ☐ |
| **Recommendation** | The Board of Directors is asked to receive and note the Annual Report. | | |
| **Summary of key elements** | | | |

**Strategic goals supported by this report**

| Excellent population health and wellbeing | x | Excellent experience receiving and providing care | x |
|---|---|---|---|
| **Excellent value and sustainability** | | | |

**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 | |
|---|---|---|---|
| **NHS England** | **x** | **Legislation** | |
| **National policy/guidance** | **x** | | |

Public

# ETHICS COMMITTEE ANNUAL REPORT

## 1 APRIL 2022 TO 31 MARCH 2023

## 1. INTRODUCTION

In line with best practice the Ethics Committee ('the Committee') should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.

1.1 The purpose of the Committee is laid down in its Terms of Reference and was established as the forum to consider the Trust's overarching moral and ethical principles, in order to provide the best quality health care to its patients.

1.2 The Committee is tasked with providing assurance to the Board of Directors that:

(i) appropriate ethical and moral reasoning is being applied to clinical decisions and novel treatments;
(ii) a framework to enable ethical decisions, to be made in accordance with the law and the principles of moral and natural justice, have been agreed; and
(iii) all patients are entitled to treatment with no arbitrary criteria being applied (such as those defined by the Equality Act as having protected characteristics) outside recognised clinical criteria and the realities of demands of the service.

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

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

## 2. INFORMATION SUPPORTING OPINION

### 2.1 Delivery of Committee's Key Responsibilities

2.1.1 During the reporting year, the Committee has delivered the key responsibilities as set out in the Terms of Reference. An ethical debate took place on the following issue:

- Clinician experiences of difficulties and challenges in delivering care

## 3. MEMBERS AND MEETINGS

3.1 During 2022/23, the Committee met formally on two occasions. The Committee was quorate for one of the two meetings.

3.2 The record of Committee attendance is shown below:

| Member | Number of meetings attended |
|---|---|
| Ian Currie | 2 (2) |
| Deborah Kelly | 1 (2) |
| Kate Lissett/Liz Thomas | 1 (2) |
| Martin Manley | 2 (2) |
| Natalie Herring/Nicola McMinn | 1 (2) |

## 4. COMMITTEE EFFECTIVENESS

4.1 A self-assessment is in the process of being conducted, the results of which will be reported to a meeting early in 2023/24.

4.2 Any areas for action identified as part of the self-assessment of the Committee's effectiveness to identify any gaps in the Committee's workings will be noted and addressed.

4.3 Although the current self-assessment process is not yet completed, the Committee has recognised that the original premise of considering ethical issues only when clinicians come forward with a desire to discuss them, has resulted in only one issue being discussed in the reporting year. Therefore, a more proactive approach is being taken to encourage, where appropriate, clinicians to present ethical issues for discussion.

## 5. 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 Board of Directors.

**Ian Currie**
**Chair, Ethics Committee**
**April 2023**

| **Report to the Trust Board of Directors** | | | |
|---|---|---|---|
| **Report title**: Chief Operating Officer's Report | | | Meeting date:<br>28 June 2023 |
| **Report appendix** | N/a | | |
| **Report sponsor** | Chief Operating Officer | | |
| **Report author** | System Care Group Directors | | |
| **Report provenance** | The report reflects updates from management leads across theTrust's 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 detail not fully covered in the IPR.<br><br>The report also highlights several key developments across the community alongside the key activities, risks and operational responses to support delivery of services through this phase of the recovery and restoration. This includes 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 goals supported by this report**

| | | | |
|---|---|---|---|
| **Excellent population health and wellbeing** | X | **Excellent experience receiving and providing care** | X |
| **Excellent value and sustainability** | 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** | 20 |

Risk Register Number 5 – Operations and Performance Standards

Public

<table>
<tr><td rowspan="3">External standards affected by this report and associated risks</td><td>Care Quality Commission</td><td>X</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS England</td><td>X</td><td>Legislation</td><td></td></tr>
<tr><td>National policy/guidance</td><td></td><td colspan="2"></td></tr>
</table>

Public

| **Report title:** Chief Operating Officer's Report | | **Meeting date:** 28 June 2023 |
|---|---|---|
| **Report sponsor** | Chief Operating Officer | |
| **Report author** | Care Group Directors | |

## 1.0 Purpose

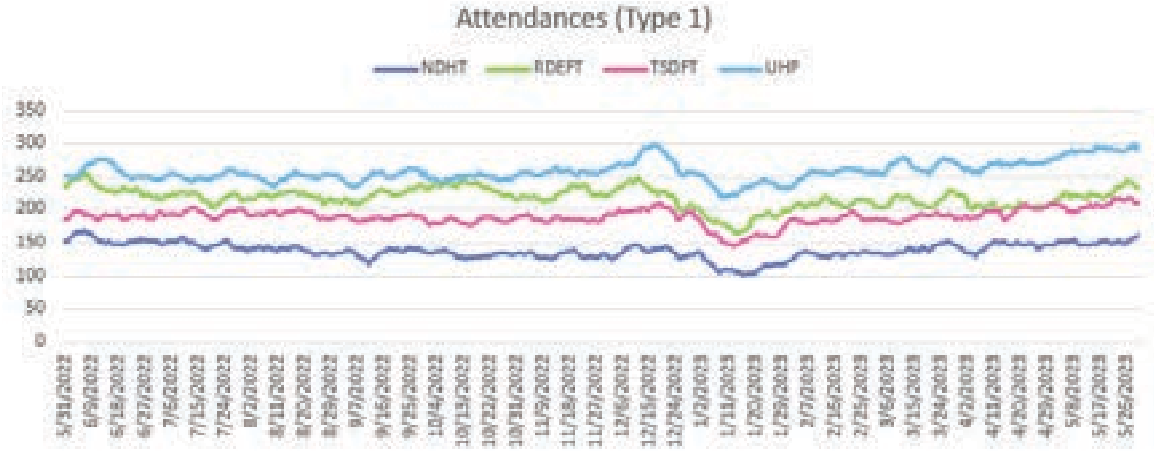
This report provides the Board with an update on progress and the controls in place in relation to operational delivery across the Trust's Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD).

## 2.0 Introduction

The month of May has seen increases in unplanned attendances, the warm weather, long weekends, and school holidays have been influential in this rise. We have also experienced several infection control challenges which have influenced flow and capacity. Planned care performance remained strong with improved trajectories met. The community teams have also noted further increases in their caseloads.

## 3.0 Urgent & Emergency Care (UEC) update

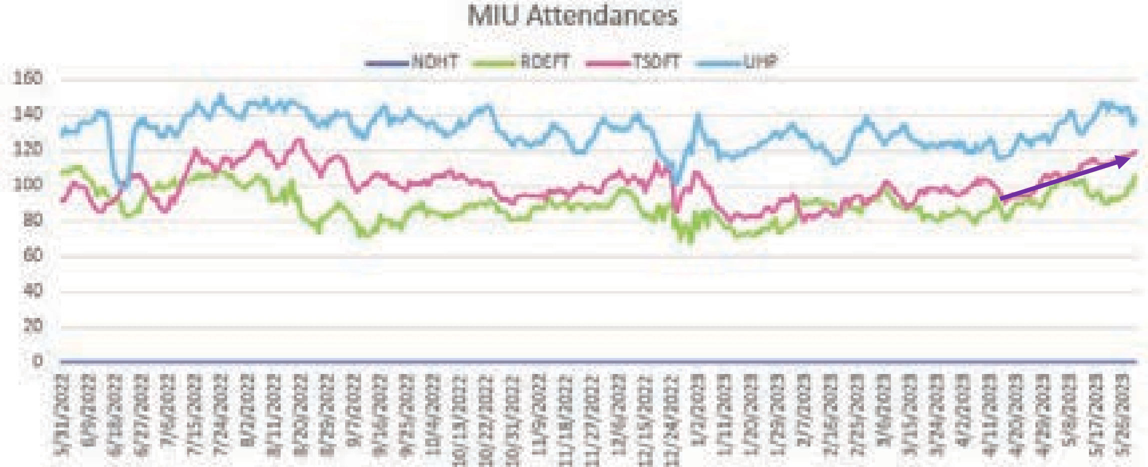
May 2023 saw an increase to 10009 Type 1 and Type 3 attendances across our estate: an increase in overall attendances of around 11.5%. Daily demand to the Type 1 Emergency Department rose from 199.2 in April to 209.2. Overall attendances increased from 5,977 to 6,488. Type 1 attendances show a steady rise from January 2023.




Our Type 3 urgent treatment centre (UTC) and minor injuries unit (MIU) attendances increased in the month from 3,002 to 3,521 – a 17.2% increase. This has been a steady rise since January 2023 and averages over 113 per day.

Comparing previous years at this point in the season daily Type 1 Emergency Department activity at 209.2 is up from 169.4 in 2022 and 196.6 in 2021.
This pattern is mirrored for Type 3 daily activity at 113 attendances for 2023 compared to 87.9 for 2022 and 87.2 for 2021.

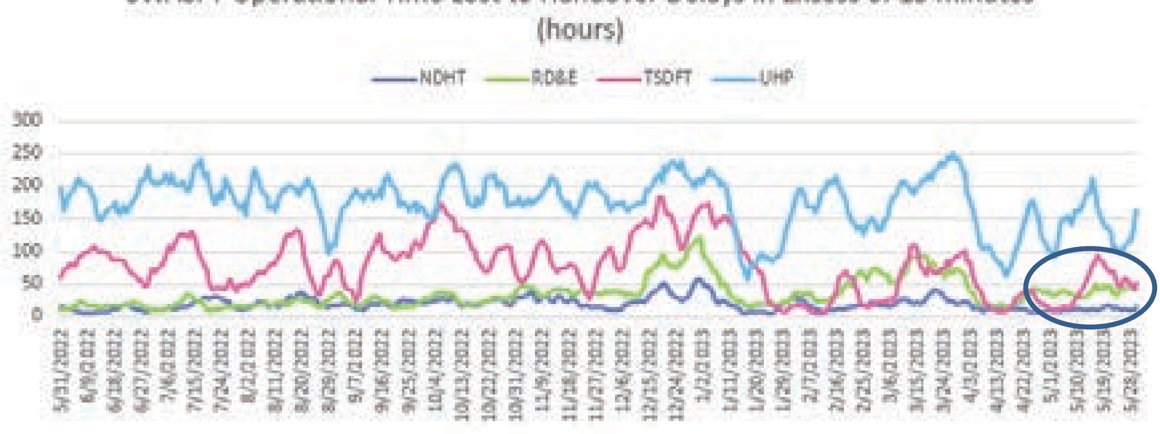
Public




The overall UEC performance was 60.83% compared to 61.74% last month. As a result, the Trust was below its recovery target of 65% for May.

**3.1 Ambulance Handovers**

The trend in ambulance handovers remains below the 2022 averages but did rise in the second week in May which correlate with infection outbreak challenges and bed occupancy being at 96-98%. It did, however, recover in the last two weeks of May.




Despite our significant improvements in reducing 60-minute plus breaches, there were several days of significant delays and holding multiple ambulances with the regrettable attendant patient waits outside the ED. The ED teams did double-up in bays more than in previous months to reduce this negative patient (and Southwest Ambulance Service Trust (SWAST)) experience where clinical risk allowed this to be done.

Other factors affecting UEC in May were high numbers of abandoned NHS111 calls – averaging 16% across the month and up to 29% over the last Bank Holiday weekend on the Monday. The average time to calls being answered is also well outside national targets at 4minutes 30seconds.

### 3.2 Inpatient Flow

We have achieved our pre 5 pm discharge target on more occasions this month but have not managed to meet the pre-noon target of 33%. Our average discharge percentage for May was 18.6% by noon and 68.2% pre 5 pm. The Flow & Ward improvement group seek to continue to drive this improvement, with a focus on pre-noon discharges, with workstreams to maintain and improve this position.

As mentioned in previous reports we have established a causative relationship between performance and a reduction in bed capacity. Although this is usually a result of infection outbreaks and subsequent bed restrictions the reduction in daily discharges due to bank holidays and school half-terms has had a similar impact. In May we had 1,696 adult ward discharges compared to 1,668 in April. With May having one more day than April this equates to a reduction in discharges of over 3% or approximately 55 beds.

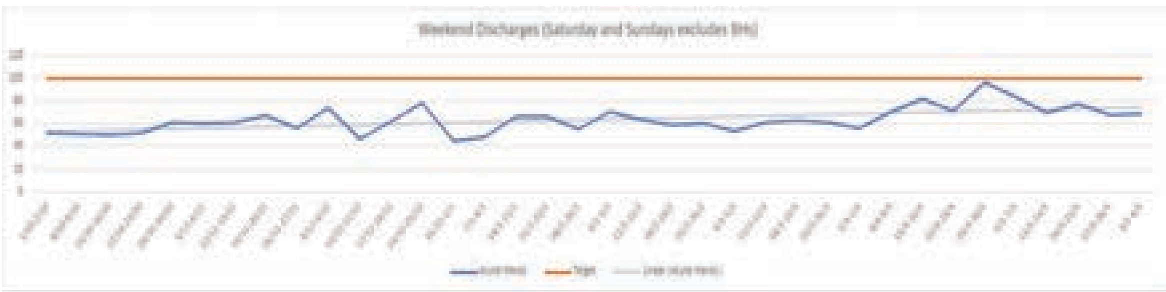
The Trust remained under extreme pressure throughout May – declaring OPEL 4 for 14 days, with a critical incident being declared for two days.

| Month | OPEL 1 | OPEL 2 | OPEL 3 | OPEL 4 | OPEL 4 + Critical incident |
|---|---|---|---|---|---|
| Dec 22 | 0 | 1 | 3 | 22 | 5 |
| Jan 23 | 0 | 7 | 6 | 18 | 0 |
| Feb 23 | 0 | 6 | 15 | 7 | 0 |
| Mar 23 | 0 | 0 | 20 | 11 | 0 |
| April 23 | 0 | 8 | 17 | 5 | 0 |
| May 23 | 0 | 7 | 10 | 12 | 2 |

The discharge lounge (DCL) remains helpful in generating timely ward capacity. With the DCL team meeting the KPI of 450 patents in May. However, further effort is needed to ensure that patients who could use the discharge lounge do so and release beds for admitting patients earlier. In May 300 patients used the discharge lounge equating to 17.6% of all adult discharges.

We saw a marginal improvement in our weekend discharges in early May. This is achieved when we are able to source an additional consultant and complete ward rounds on short stay (EAU4) and have a fully staffed medical discharge team.

As a result, the UEC Care Group are exploring options for permanent cover rather than relying on locums to provide ad hoc cover.

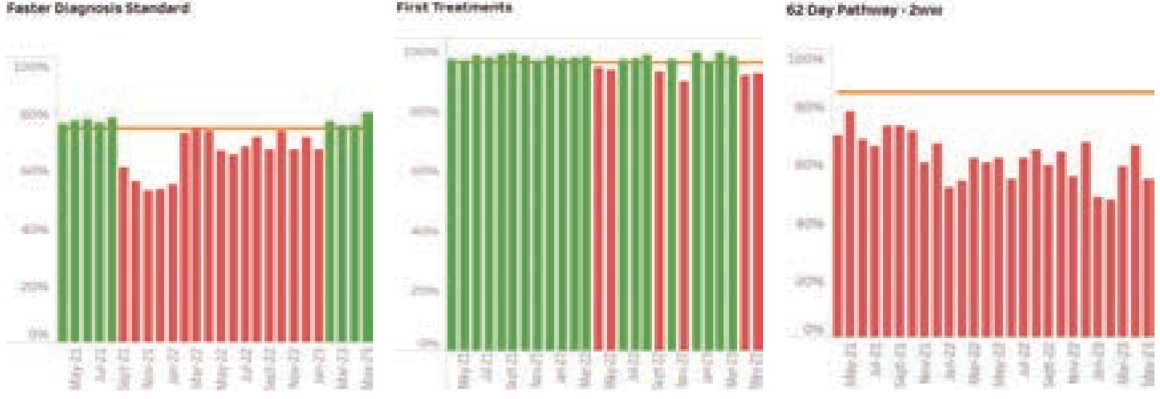


## 4.0 Cancer Performance

During the month of May, Torbay and South Devon received a total of 1,864 two-week wait referrals (2WW), which remained consistent compared to the previous year.

### 4.1 Cancer Recovery

There are four 'Key Lines of Enquiry' which are used to benchmark organisations in the NHS England 'Tiering' system. We have successfully transitioned Torbay out of Tier 1 level scrutiny, receiving written confirmation and commendation from NHS England in May 2023.

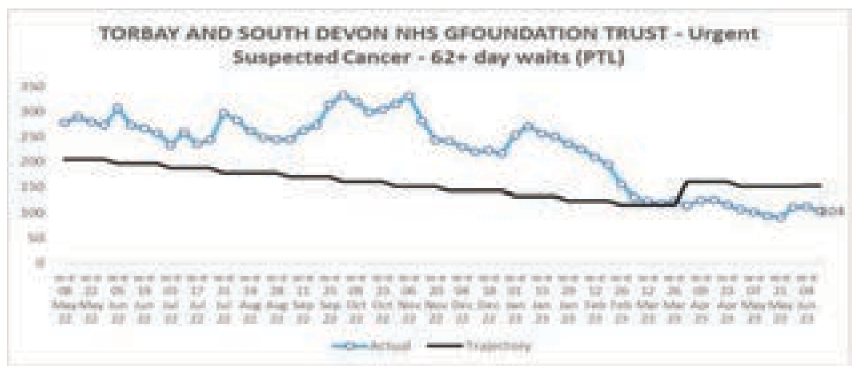



In May the Faster Diagnosis Standard has been achieved, currently at 80% giving four months of consecutive compliance against the 75% target.

31-day performance is 92%, against the 96% target, for April. Delays for Plastic surgery account for the majority of the delays, which is a service provided in partnership with Royal Devon University Hospital (RDUH) surgeons. Additional weekend sessions have been scheduled throughout June to reduce waiting times and pathway improvements, such as greater local provision for plastic surgery are being designed.

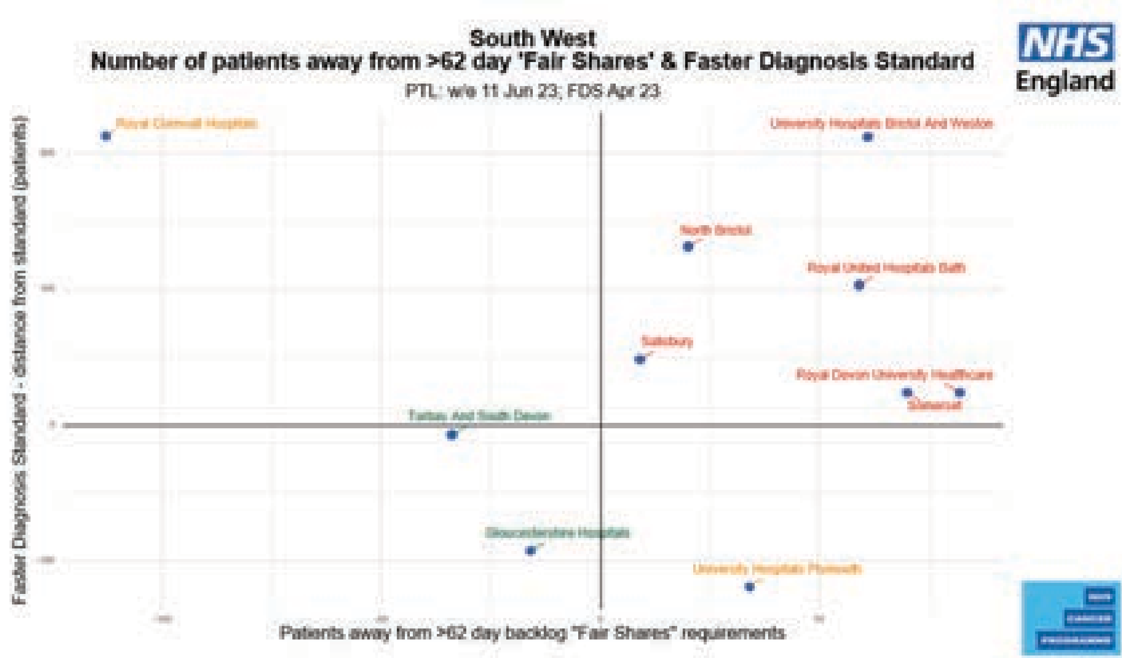
May was a challenging month for 62-day performance, achieving 55% against the 85% standard. This is in line with our work to reduce the 62-day backlog. Urology accounted for half of all breaching pathways, but during the last 12 weeks has reduced their backlog by 27 patients and is currently at 26 – the lowest point since December 2020.

**Over 62-day Backlog (Open Pathways)**
As of 11th June 2023, the number of open pathways over 62 days was 104 and represents 6.6% of the total Patient Tracking List (PTL). There are only 6 patients over 104 days.




**Regional position**
NHS England benchmark Trusts on their Faster Diagnosis Performance and 62-day backlog position, against their target (for Torbay this is 138).

This scatter plot demonstrates the strong position of Torbay, as we are achieving both benchmarked standards.




### 5.0 Referral to Treatment (RTT)

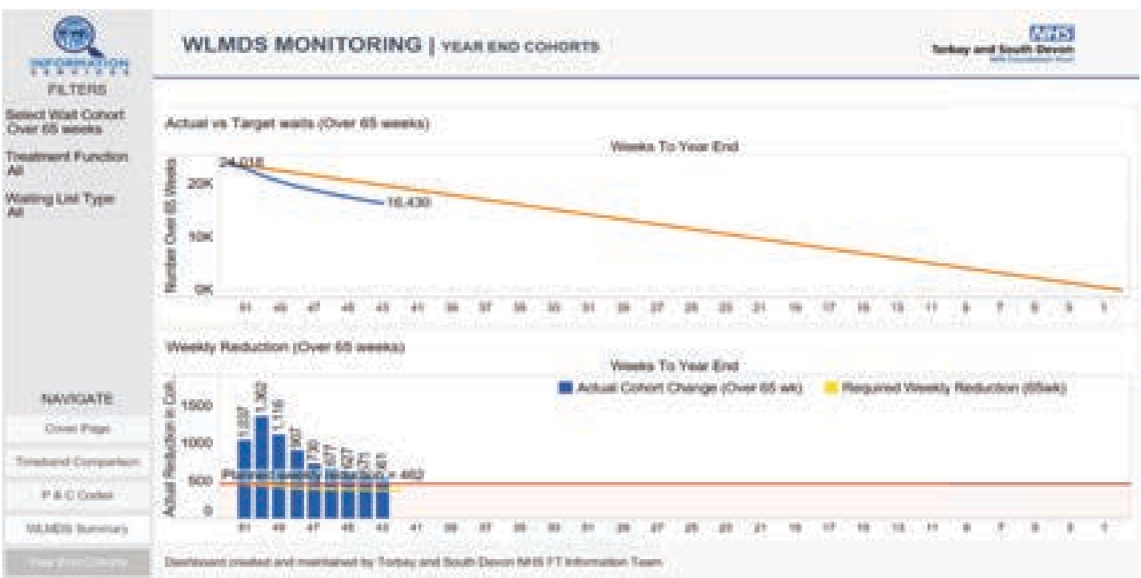
**5.1 Long waits (May 2023)**
**104 weeks –** The Trust continues to meet a performance of zero 104-week waits at the end of May, delivering on our forecast position.

**78 and 65 weeks –** Our over 78-week submission for May is 170 against our forecast of 208. The Trust has maintained strong daily clearance rates against our longest waiters

and as a result the 78-week forecast for June has been revised from 208 to 130. We are currently ahead of our plans to hit this improved position.

Our strong clearance rates have had a positive impact on our 65-week cohort (see below chart). 32% of the 65-week cohort for 2023/24 have been cleared in the first 9 weeks of the year, reducing the risk of reporting 65-week breaches in March 2024. Whilst the Trust still has specialties that are considered a risk, plans to mitigate these risks are being developed.

As a result of this the Trust has revised its 65-week forecasts to zero by 31st March 2024.




## CFHD Performance: RTT Waits

| Service | Mean Wait | % waiting ≤ 18 weeks | % RTT ≤ 18 weeks compared to last month | % RTT ≤ 18 weeks over the last 12 months |
|---|---|---|---|---|
| Community Children's Nursing (CFH Devon) | 13.3 | 73.0% | ↓ | |
| Learning Disability (CFH Devon) | 4.7 | 93.8% | ↑ | |
| Mental Health and Wellbeing (CFHD) | 21.9 | 55.9% | ↓ | |
| Occupational Therapy (CFH Devon) | 16.6 | 60.3% | ↑ | |
| Palliative Care (CFH Devon) | Null | Null | → | |
| Physiotherapy (CFH Devon) | 8.7 | 91.9% | ↓ | |
| Special School Nursing (CFH Devon) | 50.9 | 36.4% | ↑ | |
| Specialist Autism Spectrum Assessment Team (CFHD) | 41.1 | 30.9% | ↑ | |
| Specialist Children's Assessment Centre (CFHD) | 51.4 | 19.7% | ↑ | |
| Speech & Language Therapy (CFH Devon) | 33.7 | 36.3% | ↑ | |

The May waits data shows improvement in referral to treatment (RTT) and mean waits in six service areas. CAMHS (Children Adolescent Mental Health Services) RTT remains relatively stable around 60%, physiotherapy is 0.1% below the RTT target and is generally a well performing service area. Children’s Community Nursing is commonly

above the RTT target between 95-100%, but is showing a drop-in performance in May. We continue to work to establish optimum efficiency in all service areas and have waits improvement plans in services in which the performance trajectory is below target.

There are five CFHD service areas where there is a significant gap between demand and clinical capacity; namely, Mental Health, Occupational Therapy, Speech and Language Therapy, Autism Assessment, and the Children's Assessment Centre. Each of these service areas has been highlighted in the specification review work with the Integrated Care Board (ICB), as areas which are not sufficiently resourced to meet population need.

### 5.2 Waiting List Equality

The Trust is developing a Waiting List Equality plan. Based on the experiences of colleagues and patients in Somerset the plan will ensure that vulnerable patients will be supported and have their care expedited in line with their holistic needs and not only the urgency of their condition or the time they have waited. This is planned to be introduced during Quarter 2.

### 6.0 Diagnostics Performance

Our diagnostic performance has improved in May. The Trust reported 27.71% of patients waiting longer than 6 weeks against the end of May target of 25%.

MRI remains a challenge with improved performance reported in non-obstetric ultrasound and CT. The MRI risk is the result of significant workforce capacity challenges in this service. Plans to mitigate this position are being developed and include the addition of a further pad for mobile services in Newton Abbot. This pad will accommodate a mobile, and importantly, staffed Independent Sector MRI. However, the timelines for this development are at risk owing to planning regulations. Plans have been received and are in the process of being reviewed by estates colleagues.

The Trust is fully engaged in the System-wide discussions to develop Community Diagnostic Centres in Devon. This is a very important proposal which presents a range of opportunities to transform and improve elective care pathways for cancer and routine services.

## 7.0 Children and Family Health Devon (CFHD)

### 7.1 Quality Improvement / Service Improvement Projects

A number of quality improvement / service improvement projects are underway, as follows:

- Extension of the First Response Service provision to children and young people. This has involved CAMHS staff developing and delivering a training package for the staff who have previously provided the service to adults only. The Training was recognised as a good practice exemplar by Health Education England and is now being developed for use nationally.
- CAMHS Crisis Pathway Expansion. Historically there has not been an equitable provision across Devon and Torbay for crisis care in and out of hours. This project involved implementing the crisis offer across the area and extending the out of hours provision. Both projects above are aligned to NHS Long Term Plan requirements.
- Crisis NHS Learning Disability and Autism Programme (LDAP). CFHD has delivered a pilot project which established Key Workers to support young people with learning disability and Autism, who experience mental health crises. In its first year, the service achieved a 75% reduction in CAMHS inpatient admissions for this cohort of young people.
- CFHD Safeguarding Service. Historically, the safeguarding team has coordinated responses to a high number of requests for court reports in respect of private law cases, work which, is usually outside the remit of children's health services. An important piece of work has been undertaken with a local judge to change the expectations in this regard which will lead to a release of additional capacity for the safeguarding service
- Induction Programme. A project which has led to the development of a multi-media induction pack and process for all new staff commencing in post within CFHD.

### 7.2 Service user engagement

CFHD has established a Participation Board which is chaired by a parent. Work is underway to develop a support programme to enable young people to become co-chairs of the Participation Board. Multiple participation activities are underway including the co-production of new names for the CFHD clinical pathways and co-production of an engagement strategy for CFHD's new integrated service model.

### 7.3 SEND improvement work

Extensive activity continues in both Devon and Torbay in relation to the Devon Accelerated Action Plan and Torbay Written Statement of Action. There is a focus currently across the health community on refining the data reporting for each area.

## 8.0 Families Community and Home Care Group Update

### 8.1 Children's Torbay 0-19 Service

Dame Andrea Leadsom, MP for South Northamptonshire visited our Torbay Family Hubs on June 1st and saw first-hand the developments and progress being made to improve outcomes for our local Torbay families.

During the day Dame Andrea met with peer supporters, local families, senior leaders in the Council, our CEO, and members of the parenting group to learn more about the support they receive. She also presented certificates to infant feeding peer supporters who have recently graduated from their training programme. In addition, Dame Andrea met members of the parent carer panel and attended a parent baby class.

### 8.2 Community Dental Service

The service activity levels are stable compared to previous months, though the numbers on the waiting list are growing due to reduced staffing capacity and vacancy.

### 8.3 Torbay Recovery Initiatives (TRI) (Drug & Alcohol Service)

The SSMTR (Supplementary Substance Misuse Treatment & Recovery) grant funding has been received and will be focused on the service developments to support people in the criminal justice system as well as wider service support to improve outcomes for people in treatment. The co-production work is part of Alliance development with a strong group of people who have lived experience working alongside the leadership team.

### 8.4 Maternity

#### 8.4.1 Improvement in Quality Metrics – Saving Babies Lives

As well as the improvement in our carbon monoxide (CO) compliance there has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically our SATOD data was 13-15%. With the introduction of the smoke-free pregnancy team this rate has dropped to 7.3% for the year 2022/23 and for this quarter was 8.2%.

Data from the Perinatal Institute on our detection of small for gestational age (SGA) babies for this quarter has evidenced that we are still performing above the GAP user average and are one of the top 10 Trusts in the country for detection of small babies. The Trust detection rate was 69.2% compared to the National GAP average of 43.6%. This links with Element 2 of the Saving Babies Lives Care Bundle.

#### 8.4.2 Brigid Implementation progress

The introduction of the electronic observation recording and escalation system (Brigid) into maternity went live on the 5th June 2023. This was a MUST DO action from the 2020 CQC inspection. The system provides the ability for all observations to be visible within the clinical record wherever they are entered enabling prompt clinical review and escalation in the case of deteriorating patients. It also coincides with the introduction of the updated new-born observation chart (NEWTT2) This is an exciting new development in our digital maternity journey and will make care safer for women and babies.

**8.4.3 Workplace Culture**
The Professional Midwifery Advocates (PMA) hosted a conference at the TREC Lecture Theatre on 23rd May with the theme as ‘Retention of Midwives’. Speakers focussed on culture of a safe and supportive workplace. To support this culture the PMA team are also providing restorative clinical supervision with the obstetrics and gynaecology junior doctors with positive outcomes being reported.

**8.4.4 Maternity Triage working party.**
The team are working on a service improvement plan to address the mechanism by which women are able to access the service for advice, review and support. They are planning to implement a 7-day a week telephone triage phone line with dedicated team providing consistent advice and signposting. This will provide a way to risk assess women at the point of contact with the service.

**8.5 Gynaecology**
One of the senior nurses within the gynaecology outpatient department has recently qualified as a nurse colposcopist. This follows a very rigorous training course and examination. We have now been able to commence a nurse-led colposcopy service with a resultant decrease in Gynaecology medical workforce time.

A new Lead Nurse for Gynaecology Outpatients and Early Pregnancy has now started in post. This role has been increased to a full-time post and will allow the post-holder to focus on the introduction and extension of nurse led services including post-menopausal bleeding (PMB), manual vacuum aspirations (MVAs) and urogynaecology services.

The PTNS service (Percutaneous Tibial Nerve Neuromodulation) has now commenced within the Gynaecology Outpatient Department. This is another nurse-led service, where low voltage electricity is used to improve the function of the tibial nerve and improve urinary incontinence. This service is cost neutral with regards to nursing staff time and will reduce pressure on gynaecology medical workforce time and theatres time. The service will be reviewed in 6 months.

Backlogs are the same, however colposcopy has improved due to a reduction in screening referrals as we are now three years post-COVID when women were not attending their screening appointments. The figures will return to normal in July 2023.

**8.6 Community Sexual Health Service**
A service improvement approach is being implemented at the phone triage for new patients to the service. This improvement will improve face to face access, this will improve the experience for the patient, along with saving time by being asked repeated questions by two different clinicians. This was trialled in May prior to returning to walk-in clinics as pre-COVID.

Devon Sexual Health services have appointed a Practice Educator post which will cover both Devon and Torbay / South Devon area to develop the workforce. The post holder will have significant responsibility for the education and training of staff, supporting and delivering pre and post registration training as well as ongoing training for staff in line with local and national guidelines and directives.

**8.7 Healthy Lifestyles & Personalised Care**
A Personalised Care Lead Educator role has recently been appointed. The purpose of the role is to support the development and implementation of effective education and learning programmes, to enable delivery of a culture of personalised care across the health and care system, developing opportunities for collaboration within and across systems and contributing to the positive impact on outcomes.

The Lead Educator will deliver the following education and training programmes:
- PCI health coaching
- What matters to you matters
- Health Connect Coaching

Health Connect Coaching Programme:

- Health Connect Coaching has been nominated by one of our local MPs for a parliamentary award.

Cancer developments are being well supported by the clinical team and coaches with cancer experience have regular supervision by a cancer professional to support them in their role and with their peers.

**8.8 Social Care**
The Transformation and sustainability programmes continue with increasing staff engagement on the diagnostic phase of adult social care (ASC) Pathways Project alongside an external delivery partner (Newton). Learning from the deep dive workshops and data gathering has shown initial indications of areas of improvement, which will support flow from hospital and Care Act responsibilities.

Independent sector improvement networks are being formulated for delivery later in the year. The improvement network will focus on quality improvement techniques and to work together on key areas within our provider markets. Over the previous year, incremental improvements have been made to provider engagement, and the improvement network will be supportive on increasing collaboration between the Trust and our market. Providers have been working alongside Quality Assurance and Improvement Team (QAIT) where they have a Clinical Quality Commissioner (CQC) rating of 'Requires Improvement' (RI). The QAIT continue to implement the RI plan which indicates alongside our assessment tool resulting from the current Provider Assessment and Market Management Solution (PAMMS) pilot.

Low domiciliary care waiting lists are being maintained due to sufficiency in the market. Social care waiting lists remain high, however, risk management processes are in place to ensure patients reman safe. Significant work has been undertaken in the discharge to assess (D2A) window and our therapies in-reach project, which promotes flow from hospital discharge and better outcomes for our community-based patients, including reducing the potential of clients being permanently admitted to residential care.

## 8.9 Bay Wide Community Health Services

### 8.9.1 Community Nursing

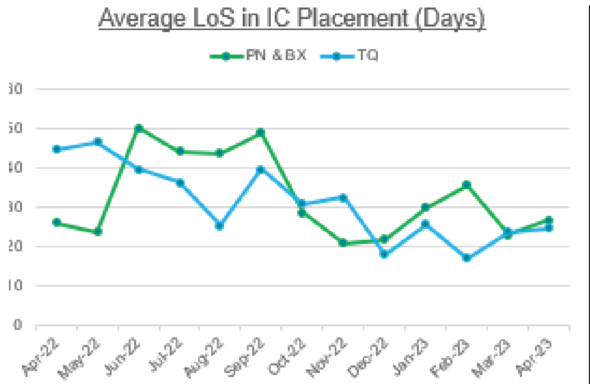
The Torquay community nurses (CNs) did 4,278 visits last month, (normal numbers are 3,800-4,100 visits a month) Paignton and Brixham recorded 3,190 visits.

The number of insulin-dependent diabetic patients that are being managed by the CN teams are continuing to increase. This continues to be a concern that is actively monitored and managed.

The call handling for community nurses out of hours has been served notice by the current provider HUC a system wide response will be required as the service is Devon wide.

### 8.9.2 Intermediate Care

The IC teams are seeing a reduction in length of stay (LOS). In bedded placements, work is underway to monitor and reduce the length of stay. The teams are managing the 17 extra block pathway 2 rehab beds in care homes to assist with hospital flow. The career promotion of IC lead in Torquay has created the opportunity to redesign and develop a Baywide response. Currently we have 40 patients across the Bay in placement, with an average LOS of 23 days.




## 8.10 Urgent Care Response (UCR)

The teams are achieving the national target in their response times, meeting the 2-hour response target, and exceeding the target for 2-48-hour response. 0-2hr=100% for TQ and 84.6% for P&B. 2-48 hr 96% for TQ and 90% for P&B.

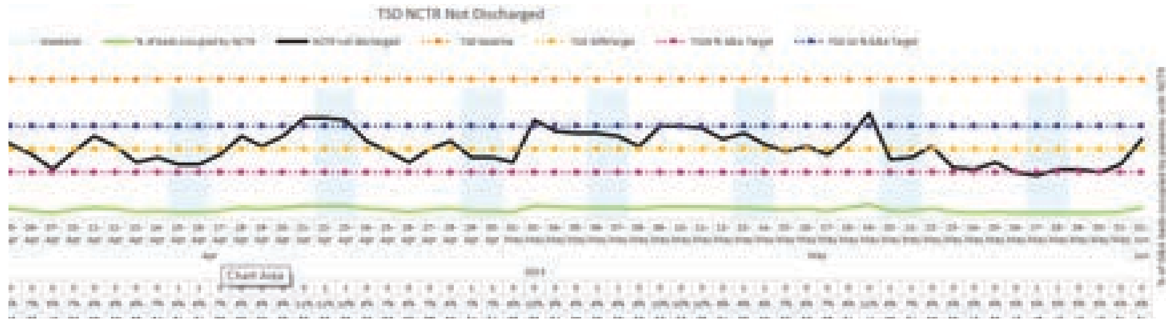
## 8.11 Complex Hospital Discharge (Pathway 1-3, excluding community hospital transfers)

Pathway 1 Time to transfer reduced to on average at 2 days, this represents and improvement in flow.

The block contract hours which support short-term service have been extended in Torbay until April 2024 using 4-week IHF funding. South Devon have extended until end of May 2023 and are awaiting confirmation from Devon County Council (DCC) regarding continuation of 4-week IHF for pathway 2 patients and self-funders past June 2023. The Care Act and a financial assessment will need to be completed whilst the patient is an in-patient for all Devon residents.

Pathway 2 - The 17 block beds provided by the demand and capacity monies are being utilised. The senior multidisciplinary team (MDT) review of all P2 referrals to the Discharge Hub is having a positive impact influencing however further improvement of the triage is required to reduce the time to transfer from seven days to five.

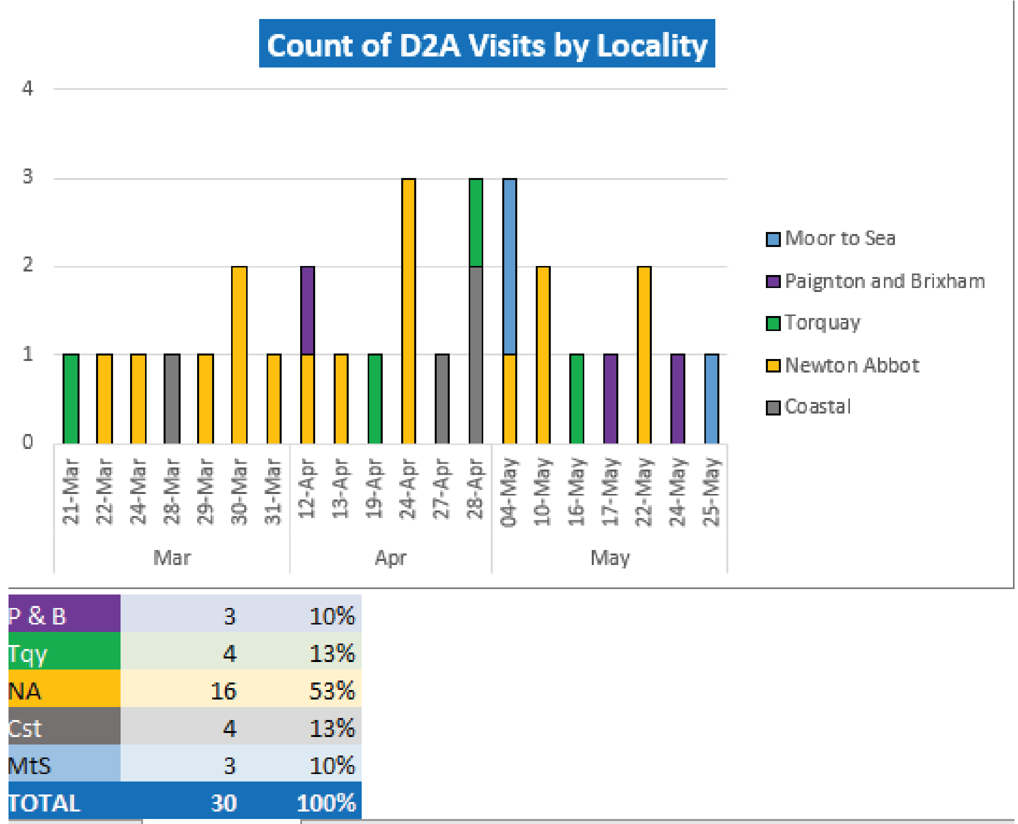
Pathway 3 - One patient with a very long length of stay remains in hospital on pathway 3 they are managed by the community teams due to their complexities and requiring bespoke support packages. A support package has been sourced and is going through the legal framework process.




Focus on reviewing the no criteria to reside (NCTR) data on Tableau has become business as usual with greater recording accuracy noted. NCTR is at 8% on 1st June 2023. It had been at 5% for seven days prior to the 1st June. Long length of stay (LLOS) for 21-day continues to be monitored by the complex team over 60% are not referred to the Discharge Hub which is being addressed through an improvement plan.

Action plans for improving NCTR is reported to the Operational Recovery Group, UEC improvement plan and the 100-day challenge meetings.

The clinicians in the discharge hub continue to complete discharge to assess (D2A) visits to support the community teams when they do not have capacity. We have commenced capturing the Data and the number of bed days saved by the discharge hub. Please see table overleaf.




| | | |
|---|---|---|
| P & B | 3 | 10% |
| Tqy | 4 | 13% |
| NA | 16 | 53% |
| Cst | 4 | 13% |
| MtS | 3 | 10% |
| TOTAL | 30 | 100% |

### 8.12 Continuing Healthcare (CHC)

Torbay and South Devon CHC team are currently achieving 80.6% against a national target for CHC decisions made within 28 days. The target is 80% and referrals remain high for both CHC and fast track.

Liaison Care have commenced their review work and the data for the first 30 clients has been sent across. Liaison have committed to review 30 fully funded CHC clients per month.

CHC appeals continue to be an area of increased activity with several local advocates taking cases up to NHS England (NHSE) for review. We maintain a position of having none of our cases overturned with a recent case commenting on the knowledge and skills of the clinical lead in Torbay.

### 9.0 Community Services and Therapies

The opening ceremony for Dartmouth Health and Wellbeing Centre was on Tuesday 9$^{th}$ May with the first patients through the doors on Wednesday 10$^{th}$ May. Dartmouth Medical Practice moved in over the last May Bank Holiday. Wellbeing Pharmacy are awaiting final regulatory inspections but hope to be open by early July. Due to ongoing concerns about access to the centre, a service user experience questionnaire is already in development for administration in late autumn once all services have been open at least three months. This questionnaire is being developed jointly by Dartmouth Caring, Dartmouth Medical Practice and the Trust and local stakeholder groups will help shape the content.

Community services in Moor to Sea ISU continue to be challenged by sickness and vacancies but intermediate care have had a series of development sessions to look at working practices which will support more efficient, effective, and patient-centred working.

A paper proposing the three to five-year approach to provision of medical cover in community hospitals is now with the care group director and deputy medical director to take forward for approval.

Challenges in the provision of therapy cover for Totnes Hospital continues as previously reported this is linked to a national recruitment challenge for physiotherapy and is also felt within acute inpatient therapies. Within the acute setting a prioritisation system continues; only patients who have been medically optimised are being seen and frequently one therapist is covering three to four wards. A therapy workforce/recruitment lead post is being put in place using vacancy slippage monies to drive through new strategies to recruitment and retention.

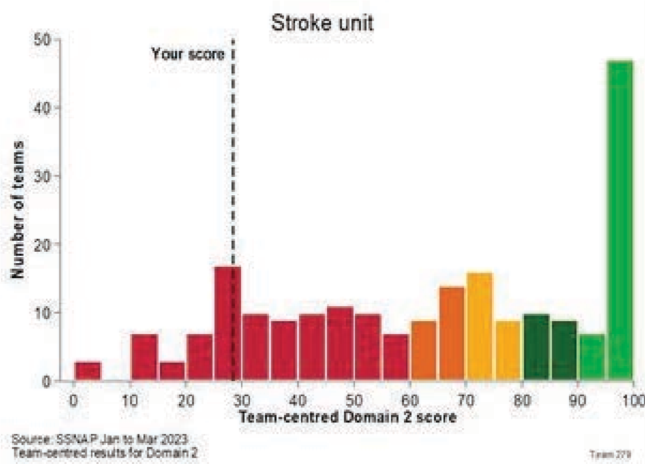
**10.0 Healthcare of Older People (HOP) and Frailty**
Scoping for the frailty virtual ward (VW) continues. An advert for a frailty VW GP is about to go out to advert and we are optimistic about appointment. We know that recent advertising by the Royal Devon University Hospital (RDUH) has been unsuccessful and so it is a very challenging area to recruit into. If successful this will allow continuation of the scoping work that our primary care colleagues Drs Kath Bhatt and Dr Matt Fox are undertaking and will expand this into tests of change and, ultimately, delivery.

Resilience continues to be an issue in HOP. We currently have locums supporting the service over the summer months.

Additionally, out of 4 whole time equivalents (WTE) registrar trainee posts, only 1.8 have been filled by Health Education England (HEE); this and our specialty doctor going on maternity leave imminently means the provision of senior support to Totnes Hospital will be a challenge that we need to resolve. We have however been successful recruiting to the two locally employed doctor (LED) posts for Totnes Hospital which is very positive.

**10.1 Stroke and Neuro Rehab**
Sentinel Stroke National Audit Programme (SSNAP) results have just been released for the January to March 2023 quarter.

At team level George Earl ward retained a D but there was some improvement. The SSNAP score was the highest since 2021, however, we are notably still struggling with access to the stroke unit, specialist assessments and speech and language therapy. Despite the ongoing work we are doing (and have reported previously) to maintain the stroke pathway we continued to benchmark poorly nationally on achievement of Domain 2 during the January to March quarter.

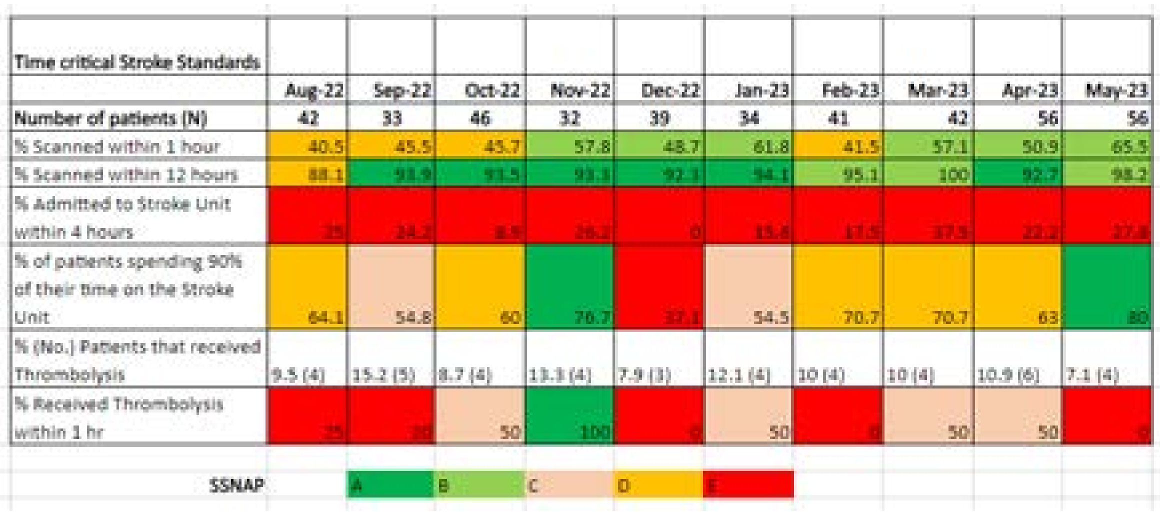



Within Domain 4: Specialist Assessment we improved against all six of the target indicators and in one indicator – percentage of patients receiving a swallow assessment – we slightly exceeded the national average. However, collectively our score disappointingly remained an E with median time to see a stroke nurse and stroke consultant being the two indicators we achieved worst on. There is an ongoing vacancy in the specialist stroke nurse team which is being recruited to but which will continue to challenge until the post is filled.

Staffing challenges within speech and language therapy (SALT) mean that scores in Domain 7 do fluctuate. This is also reflected in the Templar report below. Following recruitment SALT staffing will start to improve over the summer but it is most likely that improvements in the SALT offer for both George Earl ward and Templar ward will be felt from September.

Whilst achieving ‘A’s in five domains; a ‘B’ in one and a ‘C’ in one, Templar ward retained an overall ‘D’. This is disappointing as this is due to scoring an ‘E’ on audit compliance. This reflects delays inputting to the national SSNAP data base.

We are still trying to progress recruitment to an SSNAP administrator which will support this task both for George Earl and Templar.



| Time critical Stroke Standards | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of patients (N) | 42 | 33 | 46 | 32 | 39 | 34 | 41 | 42 | 56 | 56 |
| % Scanned within 1 hour | 40.5 | 45.5 | 45.7 | 57.8 | 48.7 | 61.8 | 41.5 | 57.1 | 50.9 | 65.5 |
| % Scanned within 12 hours | 88.1 | 93.9 | 93.5 | 93.3 | 92.3 | 94.1 | 95.1 | 100 | 92.7 | 98.2 |
| % Admitted to Stroke Unit within 4 hours | 25 | 24.2 | 8.9 | 26.2 | 0 | 15.6 | 17.5 | 37.5 | 22.2 | 27.8 |
| % of patients spending 90% of their time on the Stroke Unit | 64.1 | 54.8 | 60 | 70.7 | 37.1 | 54.5 | 70.7 | 70.7 | 63 | 80 |
| % (No.) Patients that received Thrombolysis | 9.5 (4) | 15.2 (5) | 8.7 (4) | 13.3 (4) | 7.9 (3) | 12.1 (4) | 10 (4) | 10 (4) | 10.9 (6) | 7.1 (4) |
| % Received Thrombolysis within 1 hr | 25 | 20 | 50 | 100 | 0 | 50 | 0 | 50 | 50 | 0 |

| SSNAP | A | B | C | D | E |
|---|---|---|---|---|---|

Public

In May we reported that the number of strokes admitted in April was the highest in two years; May saw the same number. Improvements in some of the key time critical standards should therefore be viewed positively, however 72.2 % (40) patients still did not get to the stroke unit in the 4-hour target.

Despite concerted efforts by the stroke MDT working with the flow team and ED in May we only reported at control meetings a stroke pathway available 42% at the time. To achieve a significant and sustained improvement in domain 2 – which will then have a consequential beneficial effect on other targets - the indications are that a minimum of two beds need to be robustly ring-fenced. Ring-fencing relies on the ward identifying patients to be discharged or move off the ward when beds become filled, and the site team working to move the patients into alternative places swiftly. These discussions will be taken through the new governance structures within the medicine and urgent care group.

Actions identified from a review of the latest SSNAP data will be added to the stroke improvement plan and managed via the stroke governance and SSNAP meetings. Within the new structure Stroke services, including some operational staff who have responsibilities across two care groups, are split across Communities and Medicine and Urgent Care; we will continue to work to ensure robust governance structures are in place to manage the whole pathway across the two care groups and performance for the whole pathway will be reported through Medicine and Urgent Care.

## 11.0 Recommendation

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

<table>
<tr><td colspan="4">Report to the Trust Board of Directors</td></tr>
<tr><td colspan="3">Report title: Directorate of Transformation and Partnerships Quarterly Report</td><td>Meeting date: 28 June 2023</td></tr>
<tr><td>Report appendix</td><td colspan="3">N/A</td></tr>
<tr><td>Report sponsor</td><td colspan="3">Director of Transformation and Partnerships</td></tr>
<tr><td>Report author</td><td colspan="3">Director of Transformation and Partnerships</td></tr>
<tr><td>Report provenance</td><td colspan="3"></td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">The Board is asked to receive and note the update from Transformation and Partnerships, covering each of the key areas within the Directorate.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information<br>☐</td><td>To receive and note<br>☒</td><td>To approve<br>☐</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board is asked to note the report.</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td colspan="3"><table><tr><td>Excellent population health and wellbeing</td><td>X</td><td>Excellent experience receiving and providing care</td><td>X</td></tr><tr><td>Excellent value and sustainability</td><td>X</td><td></td><td></td></tr></table></td></tr>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td colspan="3"><table><tr><td>Board Assurance Framework</td><td>X</td><td>Risk score</td><td>16</td></tr><tr><td>Risk Register</td><td>X</td><td>Risk score</td><td>16</td></tr></table>BAF Risk 8 – Transformation and Partnerships<br>BAF Risk 9 – Integrated Care System</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td colspan="3"><table><tr><td>Care Quality Commission</td><td></td><td>Terms of Authorisation</td><td></td></tr><tr><td>NHS England</td><td></td><td>Legislation</td><td></td></tr><tr><td>National policy/guidance</td><td></td><td></td><td></td></tr></table></td></tr>
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| **Report title**: Directorate of Transformation and Partnerships Quarterly Report | | Meeting date: 28 June 2023 |
|---|---|---|
| **Report sponsor** | Director of Transformation and Partnerships | |
| **Report author** | Director of Transformation and Partnerships | |

## 1. Introduction

The Directorate of Transformation and Partnerships supports the delivery of the Trusts strategy and leads critical strategic workstreams that support the priorities of the Trust. This paper outlines the progress against each of the strategic objectives of the directorate over the last quarter and provides assurance against key risks outlines in the board assurance framework. The paper focusses on key strategic elements of the portfolio, which includes; Trust Strategy, Provider Partnerships, Improvement and Innovation along with Communications and Engagement.

Oversight for the delivery of other aspects of the directorate are covered through Board sub-committee reports or assurance reports as part of the board pack and are therefore not repeated in this document. This includes: Building a Brighter Future programme assurance and Digital Strategy delivery and IM&T assurance.

## 2. Progress against key objectives

### a. Trust Strategy Review

The development of the Trust Strategy was successfully concluded and approved in Spring 2022, marking the first re-fresh of the Trust strategy since forming the Integrated Care Organisation in 2015. On approval the Trust Board recognised that the Trust strategy would be informed and further developed through wide and meaningful engagement with our teams and our stakeholders and this has taken place over the last year.

Throughout Spring 2023 a number of people have been involved in the review of the strategy document, the outcomes of which will be presented to the Trust Strategy Group on 30$^{th}$ June 2023 and onto Trust Board in July 2023. The formal review will provide further assurance of the alignment between the Trust Strategy and the Devon Joint Forward Plan, which was supported at by the Trust Board in May 2023.

The outcomes of the strategy review are broadly positive and will provide evidence that our staff and stakeholders are supportive of the strategic direction of travel and high-level plans. As intended there are improvement opportunities identified, the most significant of which is the clarity of the connection between our corporate strategy, operational planning and to ensure that our core strategic priorities are reflected in all aspects of day to day work, through our annual performance development review processes.

The next phase of communications and engagement with staff and partners is focussed on our strategic goals and priorities, prompting discussion around “What it means for my service and me” and inviting feedback.

Our online "Strategy Hub" continues to provide a central reference point for staff, where they can find strategy documents, other high-level plans and a "strategic news feed" regularly updated with relevant information.
The Trust Strategy Group, which brings together Chairs, CEOs, Executive Directors, wider corporate senior leaders and our Care Group leadership teams, oversees the development of the Trust Strategy and will receive the final draft of the review and proposals for improvement, which will be recommended to Trust Board on 26th July 2023. There will be sessions with Trust Board members individually and as a group to explore their experience with the strategy over the last year and to incorporate their views into the final document.

**b. Provider Partnerships (BAF 9)**

As a trust we recognise that all of our six strategic priorities are underpinned by the strength of our partnerships across our Integrated Care System (ICS). Key risks associated with this objective are described in the Board Assurance Framework (BAF risk 9.)

The directorate provides critical leadership capacity into maintaining key strategic partnerships and support for ICS workstreams to create system solutions for organisational challenges and discharges its accountability through key workstreams in the ICB, ensuring effective oversight and delivery of the work through Trust assurance groups.

The trust priority to meet the statutory standards as related to the System Oversight Framework (SOF4), is delivered through two mechanisms;

- Robust delivery of trust improvements, which will be outlined in the improvement and innovation section of the report
- Robust delivery of system schemes, that are intended to provide greater efficiency and effectiveness by ensuring that there is One Devon approach to the design of support services.

The trust has ensured that there is effective leadership at executive level into the Devon recovery plan, which reports directly into the trust recovery group, chaired by the Chief Finance Officer. Currently the focus of this work, is the development of ambitious plans to meet our system statutory objectives. The next phase of this work, will require the trust to ensure that there is sufficient capacity, capability and oversight to ensure that we deliver against these plans.

The Peninsula Acute Provider Collaborative (PAPC) has active leadership engagement from the Chair, Chief Executive, Chief Medical Officer, with the Director of Transformation taking a leadership role in the design and delivery of the Peninsula Acute Sustainability Programme, alongside key members of the directorate leadership team. This work is focussed on developing cohesive system partnership discussions to find solutions to some of our most challenging problems.

In addition to providing executive leadership into clinical pathway workshops, the directorate supports the Chief Medical Officer to ensure that our teams are supported to bring system ideas into the organisation, to ensure that there is wider clinical and operational engagement in emerging proposals.

The directorate is providing critical leadership capacity and capability into the Peninsula response to the development of solutions to some of the trusts most fragile services, which aligns to key areas of operational and clinical risk that have been outlined through the trust governance routes. This work has developed to a good level of maturity for some services, including Urology and Interventional Radiology pathways, however is hampered by a lack of resource to support the delivery phase. This has been escalated to the PAPC, and the Senior Responsible Officer for PAPC has agreed an action to identify required capacity for delivery of PASP objectives accordingly.

The Local Care Partnership (LCP) in Torbay and South Devon has strong partnership foundations, but is on a maturity journey to develop a cohesive plan to address key priorities that meet the needs of our local community. In April 2023, the LCP undertook a stock-take of its form and function, and benchmarking its maturity against other LCPs in Devon. There is planned developmental support for all LCP's across the ICS and a request for improved clarity in the structures that will provide assurance to all partners that this work will deliver the objectives within the Devon Joint Forward Plan. Locally it is expected that recent workshop will ensure that local partners are in a position to agree the Torbay and South Devon plan for improvement over the next quarter.

### c. Improvement and Innovation (BAF risk 8)

The Trust approved the Improvement and Innovation (I&I) strategy in the July 2022 and over the last few months intense activity has been undertaken to recruit and develop our capacity and capability of this team to ensure that the trust recovery plan is underpinned by quality improvement and redesign to sustainably deliver safety and quality, performance and financial improvement.

There has been a real focus to ensure that all improvement activity and resources are targeted at delivery of SOF 4 exit criteria and Trust Quality goals.
Delivery of Improvement activity is highlighted below:

Improvement Delivery Highlights in Planned Care

- The surgical transformation portfolio has worked to deliver quality improvement throughout surgical pathways and theatres. The group has achieved delivery of a preoperative assessment improvement**,** building the pool of patients ready for surgery. This work will support the delivery of best practice 6-4-2 processes. Overall there has been a reported increase of 4 weeks' worth of operating capacity and a reduction in on the day cancellations from 28% (pre-intervention) to 9% (post capacity injection).

- Theatre productivity and utilisation is a key national priority. Focusing on delivery of the national standard to achieve 85% touch-time utilisation, the improvement team have supported main theatres through the provision of an in-depth data analysis, literature review and observations to understand their current position and identify where the greatest opportunities are for improvement.

  On 26th June, the orthopaedic team will be the first to undertake a PDSA cycle, applying principles and processes that should support attainment of the outputs and benefits associated with the "Golden Patient" theory.

  The overarching aim is to:

(a) Reduce the average late start from 32.9 mins (baseline Q4 22/23) to 15 mins by end Q2 23/24
(b) Increase list utilisation from 79.2% (baseline Q4 22/23) to 85% by end Q2

- We have invested time and resource into developing our Booking & Scheduling team who are central to delivering surgical services. Through a redesigned training and development plan, and series of team development interventions, the team has been recruited to 100% capacity with good staff retention and team morale.

Improvement Delivery Highlights in Child Health

- Ongoing delivery of a rapid improvement plan for SCBU to improve the unit's *Pathway to Excellence* rating, which has included pathway and process redesign (pain scoring, HDU/ICU charts, documentation, well organised ward sessions, parent involvement). As a result of delivery of the rapid improvement plan, the unit's *P2E* rating has improved from a white level in March 2023 to a bronze rating in May 2023.

- A confirmed pathway for paediatric specialist clinical nurses has led to the development of a referral proforma and supporting SOP for the epilepsy service ensuring children, young people and their families/carers receive a consistent pathway of care and support. A digital epilepsy training package is soon to go live, enabling stakeholders across the community (e.g. teachers, social workers, school nurses) to access training on management of epilepsy within their professional setting. Project briefs and improvement action plans have been developed for the paediatric specialist clinical nurses working within eating disorders, rheumatology, endocrinology and allergies/respiratory.

Improvement Delivery Highlights in Unscheduled Care

- There has been an uptake in Respiratory and Cardiology Virtual Wards (VW) supporting 24 patents and exceeding our virtual ward occupancy target for the period of 9-15th June. Operationalisation of the Frailty VW model is currently underway, with a go live date of September 2023.

- Between 23rd May – 13th June, the I&I team attended medical wards to audit patients discharged following a weekend. The audit focussed on weekend discharges, but also encompasses discharge planning enabling increased pre-noon discharges. This work informs the delivery of our emergency care priority to improve the number of people discharged home earlier in the day and to reduce variation in discharges over the weekend.

- The Emergency Department are being supported with the planning and delivery of improvement activities, including dedicated porters to support flow, bloods being taken by paramedics in ambulances for patients and dedicated nurses to support triage and flow.

Improvement Delivery Highlights in Community and Independent Sector

- Following successful delivery of the Smart Tech project where 25% of care homes in Torbay and South Devon are supported to upskill staff to become digitally competent to support residents in using smart technology, Healthwatch has been awarded funding to implement Phase 2.

- Enhanced Health in Care Homes Delivery Group are collaborating on the creation of a set of webpages that will act as a single point of information so that care homes can access everything they need from one main space rather than having to make multiple calls or emails to find out about the services they need.

- The delivery of RESTORE 2 is being enhanced by the introduction of a digital application, designed by the education team and piloted with 10 Care Homes. It will provide a consistent approach to assessing the deteriorating patient and provides a comprehensive falls prevention assessment tool, with a commissioner dashboard which will provide population-level data on the incidence and prevalence of falls.

Improvement Delivery Highlights in Quality and Patient Safety

- Progress towards the Patient Safety Incident Response Framework delivery in early 2024 continues with the implementation of a team education session on the 15th June for 23 members.

- The Sepsis accredited e-learning modules are now live on HIVE. A communications drive is planned along with support from Sepsis champions and Practice Educators. The current Sepsis policies remain ratified until September, when it is hoped the refreshed guidelines will be published, allowing the completion of the Trust wide Sepsis policy. With the support of Formic, agreed Sepsis questions will be added to ward audits to check on compliance.

Improvement Delivery Highlights in People Promise

- Following approval of the “Compassionate Leadership Framework” by the Trust Board the People team are working collaboratively with the improvement team to embed this into our Trust processes in support of ‘Creating a Culture of Impactful Learning and Improvement’.

- The rollout of eRostering across the Trust will be restarted following financial approval to extend user licenses. This will contribute towards significantly improved efficiencies of staff rostering across departments and reduced dependency on temporary staffing.

Building Capability in Improvement

- The team held their first successful Pop-up improvement café across a number of clinical sites on the 16th May. Staff came to talk to about their ideas and to learn of improvements that taking place across the Trust.

- The Introduction to Improvement and Innovation interactive workshop was launched with a number of dates scheduled across the summer and

autumn. This short course introduces staff to how to do improvement and in particular supports the successful use of our Quality Boards.

- The 4-day Improvement and Innovation practitioner programme commences on the 27th June with over 30 staff, all bringing a range of projects to work during their learning. It is hoped that as number of those successfully completing this programme will join previous alumni in becoming Improvement and Innovation Champions – further raising the profile and importance of quality improvement and providing support to their teams in driving positive change.

- The team has also supported the Pathways to Excellence Council Training, Preceptorship programme and ad-hoc sessions for teams across TSDFT and beyond (including Rowcroft Hospice)

**d. Communications and Engagement**

We have now successfully concluded recruitment to all vacant posts and the new structure is in place and we are seeing improvement in the way we are connecting with our staff, patients and communities. The current focus of the team is to ensure that we deliver our strategic promise to move from “transmission communications” to meaningful conversations and this shift has been the cornerstone of the engagement plan that supports the delivery of our Regain and Renew approach.

Our Regain and Renew approach marks the start of a new way of working, which is a step change in the way our leadership teams connect with our staff to deliver our strategic objectives and the rapid improvements required to delivery our recovery plan and exit from SOF4. The communications and engagement team have developed an engagement framework that is supported by all members of the Executive and senior leaders across our care groups and corporate services which will:

- Improve our focus on quality and patient safety in everything we do
- Support the delivery of the compassionate leadership framework and our people promise
- Delivery of our improvement and innovation strategy, engaging and supporting our teams to deliver real improvement at pace

This ambitious programme of engagement ensures that meaningful conversations that drive our improvement activity take place in every team across the Trust, supported by the Executive and senior leaders. Each care group and corporate service has a nominated Executive and senior leaders to provide ongoing support to improve connectivity between our front-line services and leadership team.

The first phase of the Regain and Renew engagement programme was tested in May 2023 and formally launched in June 2023. Over the next few weeks our focus is to ensure that all teams are visited and this will provide a reset our leadership compact through meaningful conversations.

The engagement activity is monitored weekly through the Trust Executive group with initial lead measures focussed on ensuring that every team is visited and their feedback and ideas for improvement are captured. This will form the basis of a set of rapid improvement activity to ensure that all teams are taking control of improvements in the way they work, to achieve our common aims.

This fundamental shift in the ethos of our communication and engagement activity has required us to move to a more proactive approach to our work, identifying stories that show how we are addressing our challenges, celebrating our successes and putting our people at the heart of everything we do.

## 3. Governance and oversight

The Trust has recognised that the need for transformational change through strategic partnerships, a relentless focus on developing our capacity and capability for improvement and a fundamental shift in the way we connect and engage with our teams is a critical aspect of our business. Additionally, the directorate leads key strategic programmes to transform our digital infrastructure through an electronic patient record (EPR) and more extensive use of digital tools and remote monitoring, which will inform the development of our new hospital through the Building a Brighter Future programme. The Trust has been allocated a significant level of public funding to improve our infrastructure. We are committed to ensuring that this investment delivers real transformation in the way our services are delivered and provides better outcomes and experience for our patients.

The Trust Board has recognised that the level of criticality of this strategic work justifies greater assurance oversight and a proposal is being developed to strengthen the way the progress of this work is reported to Board. This proposal will be considered by the BBF Committee in July 2023 for recommendation to Trust Board.

## 4. Recommendation

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

| Report to the Board of Directors | | | |
|---|---|---|---|
| **Report title**: Chief Executive's report | | | Meeting date: 28.06.23 |
| **Report appendix** | | | |
| **Report sponsor** | Chief Executive | | |
| **Report author** | Associate Director of Communications and Partnerships | | |
| **Report provenance** | Reviewed by Executive Team 20 June 2023 | | |
| **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 is asked to receive and note the Chief Executive's report. | | |
| **Summary of key elements** | | | |

**Strategic goals supported by this report**

| | | | |
|---|---|---|---|
| **Excellent population health and wellbeing** | ✓ | **Excellent experience receiving and providing care** | ✓ |
| **Excellent value and sustainability** | ✓ | | |

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

| | | | |
|---|---|---|---|
| **Board Assurance Framework** | ✓ | **Risk score** | |
| **Risk Register** | ✓ | **Risk score** | 20 |

BAF Risk 1 – Quality and Patient Experience
BAF Risk 2 – People
BAF Risk 4 – Estates
BAF Risk 5 – Operations and Performance Standards
BAF Risk 8 – Transformation and Partnerships
BAF Risk 9 – Integrated Care System

**External standards affected by this report and associated risks**

| | | | |
|---|---|---|---|
| **Care Quality Commission** | ✓ | **Terms of Authorisation** | ✓ |
| **NHS England** | ✓ | **Legislation** | |
| **National policy/guidance** | ✓ | | |

Public

| **Report title:** Chief Executive's report | | **Meeting date: 28.06.23** |
|---|---|---|
| **Report sponsor** | Chief Executive | |
| **Report author** | Head of communications and engagement | |

**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 31 May 2023 are as follows:

**3.1 <u>Excellent population health and wellbeing</u>**

**Health matching programme receives prestigious parliamentary award**

I am incredibly proud that our Health Connect Coaching team has won the South West Volunteer award category in the 2023 Parliamentary Awards in recognition of its work to help people in Torbay and south Devon to take control of their health and wellbeing.

Health Connect Coaching was designed by our people and patients, and matches people who may be struggling to manage their health and wellbeing with a trained peer coach who has experience of the same condition or challenges they face.

People with a long-term condition such as diabetes, asthma, rheumatology, and chronic pain can refer themselves to receive tailored one-to-one support during the six-month programme. With the help of a coach they are encouraged to make

simple but long-lasting changes to their life such as taking gentle exercise or changes to their diet, and signposted to services and support. It's designed to encourage, support and empower people to build their knowledge, skills and confidence in a way that matters most to them, reduce their dependency on medical interventions and live well to manage their condition.

It's a great example of how we are taking a personalised approach to healthcare, and working with people to create the support they tell us they want, avoid hospital care and just get on with their life.

The team will now go forward to the national awards, which takes place at the Queen Elizabeth II Centre in Westminster, London, on Wednesday 05 July – the NHS' 75th birthday.

I would like to thank our two MPs, Kevin Foster and Anthony Mangnall for nominating the team, and also our incredible volunteers whom, without their support, we could not run Health Connect Coaching. Thank you.

**NHS75 celebrations**
We have a number of events and activities planned to help us celebrate the 75$^{th}$ birthday of the NHS next month including the launch of our long-service awards, our great Torbay and South Devon bake off and cake off, our NHS75 quiz and much more. We hope that many members of our communities will join us in celebrating this important landmark in our NHS history.

Four of our colleagues will be attending the NHS75 service at Westminster Abbey as our representatives. In addition, two colleagues have been invited to a reception at Downing Street on the NHS birthday.

**Carer's week**
Most people don't realise they are a carer, yet more than 32,000 people across Torbay and South Devon regularly support a friend or relative with their shopping, cooking meals, attending appointments with them, or just making sure they're okay. Some of our people also provide extra care for their loved ones when their day job ends.

I would like to thank Torbay Carers for organising a range of events during June's carers' week celebrations to raise awareness of the help that's available to support people. I believe all carers are important and we want to actively support and work in partnership with carers to get the best outcomes for both them and the person for whom they care. Our carers' policy and action plan is our organisation's commitment to achieving this for our people. More information about the support available to carers is available on our website.

**Minister celebrates how our family hubs are leading the way for our families**
Becoming a parent doesn't come with an instruction manual and we know some parents can find it a challenge. We're committed to giving children the best start in life, and help parents to be the best they can, and I was proud to show Dame Andrea Leadsom MP some of the incredible work of our trailblazing 0-19 service when she visited two of the new family hubs at the start of the month.

The first 1000 days of childhood are critical and our 0-19 service provides invaluable help and advice on feeding, vaccinations, bladder and bowel issues, oral health and teething, sleep and mental health support and much more from our three family hubs, and also online support from healthcare professionals, and peer supporters.

Earlier this year, Torbay Council was chosen by the government as one of 14 trailblazer local authorities to lead the way in delivering them. The services have been developed with local parents and carers alongside the voluntary and community sector to ensure their needs and those of their children are met.

Dame Leadsom visited the Beehive in Paignton, where she met Action for Children and council staff and spoke to members of a parenting group. At Zig Zags, she chatted to a mum who has received support from the hub's Better Start team. She also discovered more about peri-natal mental health and spoke to professionals who lead the Building Babies Brains programme.

Our 0-19 team does a brilliant job supporting families and proving the wraparound care they need in those critical early days. Thank you so much.

**New benefits advice service for Devon cancer patients**
Managing cancer can impact on your finances at a time when people should be focusing on their health and wellbeing. For people with cancer rising living costs comes on top of the existing financial impact that a diagnosis can bring – a drop in income due to not being able to work, extra costs such as travel to frequent hospital appointments or having the heating on more due to feeling the cold.

We are pleased to support Macmillan Cancer Support and Citizens Advice's new county-wide service which offers money and benefits advice to people affected by cancer and their families in Devon.

This newly expanded service will offer free, confidential and expert advice to people affected by cancer about benefit entitlements, financial support available to them and wider issues such as housing, debt and work. It will bring seven new Macmillan Benefits Advisers to Devon and will connect up and build on existing services to ensure rising demand for welfare benefits advice can be met and help is more easily available no matter where you live in the county.

Anyone in Devon who is affected by cancer and is worried about their finances can contact the service for advice by calling 0808 175 4505 or talking to our cancer information and support service.

## 3.2 Excellent experience receiving and providing care

**Current pressures**
Over the past month we have seen increases in the number of people attending our services unplanned. The combination of warm weather, three bank holiday weekends in May and school holidays is thought to be a catalyst for this rise. We have also experienced several infection control challenges which has affected our ability to get people home as quickly as we would like and to admit people from our emergency and assessment units in a timely manner. Our community teams continue to see increases in their caseloads.

Our performance in planned care services has remained strong and we have maintained our improvement trajectory despite ongoing industrial action which resulted in a small number of planned appointments and procedures being postponed.

We are currently ahead of plans to hit our improved position on 78-week waits and by the end of this month should have reduced the number of people waiting for over 78 weeks to 130. We have also reduced the number of people waiting over 65 weeks and while we still have specialities that are considered a risk, we have been able to revise our 65-week forecasts to set a target for zero by 31 March 2024.

**Care Quality Commission visit**
The Care Quality Commission (CQC) undertook an unannounced inspection visit to our emergency department, medicine (including care of the elderly) and outpatients' department last month. A second unannounced visit took place last week and focused on our diagnostics and imaging services.

The visits gave us an opportunity to share our successes and the work we are doing to address our challenges. The initial feedback we have received highlighted that inspectors were impressed by how open and engaged our teams and services were with the inspection process.

The CQC will return to complete our well-led inspection in July. I would like to thank everyone for their support and help to prepare for the visit.

**Launch of our new alcohol withdrawal syndrome support**
Around one in 10 people in hospital are thought to be alcohol dependent, and we're committed to supporting them while they are in our care.

This month we launched our new guidance on alcohol withdrawal syndrome which will help us identify and support people with alcohol dependency and ensure they receive support from our Alcohol Aware Team (ACT).

ACT aims to reduce the stigma of talking about alcohol habits, guide patients through community care, and ultimately reduce repeat admissions to hospital as a result of alcohol-related complications.

**Privacy, dignity and respect awareness week**
Making sure people's privacy and dignity are respected while they are under our care is something we take incredibly seriously. Some of our people took part in a number of activities during June's privacy, dignity and respect week to help us understand how we can improve the care we provide and ensure people's dignity is maintained.

Some of our ward teams were encouraged to wear a hospital gown and walk in the shoes of a patient who is cared for in their area. They did things such as finding out what it's like to eat lunch lying down while wearing a gown, sitting in a waiting room in a gown while waiting for care, and finding out how it feels to have a stranger delivering their personal care.

While the activities were meant to shine a light on a serious subject, it also allowed us to better understand people's experiences and we will now review our learning to identify areas where we can improve. This includes ensuring children stay in their own clothes or pyjamas for as long as possible before and after surgery to help them feel comfortable.

**Promoting the importance of nutrition during dieticians' week**
Our dietitians play an important role promoting the importance that nutrition plays in having good health, disease prevention and the treatment of acute and chronic medical conditions.
We have more than 25 whole time equivalent qualified dietitians, with 40 people including dietetic support workers and administrative colleagues working across a range of areas including paediatric, diabetes, community, cancer services, weight management and acute.
The team took to our wards during June's dieticians' week to raise awareness of their important work and the support they can give people under our care.

**Congratulations to our latest PRIMROSE and DAISY award winners**
Our latest Primrose award winner is Sadie Bee from our rapid response team.

Sadie was nominated by a colleague for always going above and beyond and making sure that every person she sees has 110% of her care. Many families have contacted us after Sadie has visited their relatives to say how amazing and caring she is. Families have said that if a relative is end of life, she ensures everything is done to make them feel as comfortable as possible.

We were delighted to welcome Melissa Barnes from the DAISY Foundation for a visit earlier this month, where she presented the two latest DAISY Award winners.

The DAISY Foundation was set up 23 years ago in memory of Patrick Barnes, Melissa's brother in law, and has since then recognised outstanding care from over 200,000 nurses and midwives in more than 25 countries worldwide.

Helen Thatcher, who works in Dawlish Community Hospital, was nominated by a person in her care who described her as "going above and beyond" to recognise her deterioration and to lead and advocate for her care. It went on to say "Helen was leading an entire hospital that Saturday. She showed me individual care and compassion."

Mars on Allerton ward was nominated by the family of a patient who sadly passed away. Mars was recognised for outstanding levels of professionalism, compassion and respect during what was a difficult time.

Members of the public and colleagues can nominate a nurse or a midwife who has provided outstanding care for a DAISY award. Health care support workers who provide outstanding care can be nominated for a PRIMROSE award.

**Our midwives scoop more top awards**
I am delighted to share with you that our midwives Katie Aston, Josephine Ash, Jacqueline Crown and Joanna Bassett have won a number of awards this month, recognising their commitment to supporting people in their care.

Katie was awarded a prestigious Silver Chief Midwife Award for helping more than 150 mums and their partners to quit smoking during pregnancy. Katie was presented with her award by the deputy chief midwife for England, Jessica Read.

Katie was also a runner-up in the rising star category of the South West maternity and perinatal awards where her colleagues Josephine Ash and Jacqueline Crowe, our retention team midwives, won an innovation award for their work to retain our midwives.

Joanna Bassett, associate director of midwifery and professional practice, was also named runner up in the leadership category.

**Ward accreditations**
Four ward accreditations have taken place in the past month using our revised scoring system of white, bronze, silver and gold.

Warrington ward achieved bronze while Ella Rowcroft and EAU4 achieved silver. Our coronary care unit (CCU) achieved a fantastic gold – only our second gold under the new scoring system. Well done to everyone involved.

**3.3 Excellent value and sustainability**

**Government announces its continued commitment to Torbay Hospital**
On 25 May the government announced its continued commitment to support our work that will allow us to deliver modern day healthcare in our community, and better working environments for our people.

We are really pleased that Torbay Hospital continues to be included in the government's health infrastructure programme, also known as the New Hospital Programme plans. This is a really exciting announcement, which will bring huge benefit to people in Torbay and South Devon who need our care, and also our people who work here. It means we can continue with our plans to incorporate modern hospital designs in to our buildings, making use of the latest technology, digital innovation, and sustainability.

Steve Barclay, Secretary of State for Health and Social Care, said that our programme would be completed by 2030. We await official confirmation of our funding allocation and the timescales for our programme.

**A big step forward for health and care services in Teignmouth**
Teignbridge District Council approved our plans to build a new health and wellbeing centre in Teignmouth.

Located on the Brunswick Street site, in Teignmouth town centre, the new £17.3million state-of-the-art facility will bring GP services, and health and care and voluntary sector services under one roof.

GP services provided by the Channel View Medical Group will be based at the new centre together with community nurses, social workers, health and wellbeing teams, therapists, podiatry, audiology, physiotherapy and voluntary sector

services. The purpose built, facility will also support the delivery of technology enabled care, helping more people live well in their communities.

While there are still a number of processes to follow before construction can begin on site we are now a significant step closer to being able to offer seamless health and wellbeing services for local people in the heart of Teignmouth. We estimate that once construction begins, the building work will take approximately two years to complete.

I acknowledge that some local people have continuing concerns about the future of the Teignmouth hospital site and we have invited key local stakeholders to meet with us next month to agree how we will involve local people in conversations about the future of the site.

When the new health and wellbeing centre is built, a number of clinical services will move from the hospital into the new building while other clinical services will transfer to Dawlish community hospital or other sites. We will make sure that people are given plenty of notice of the date of any changes and will work closely with partners in Teignbridge District Council and the voluntary sector to address any issues around transport.

**Ground-breaking work continues as NHS Nightingale Hospital Exeter helps to further reduce Devon's waiting lists**
The South West Ambulatory Orthopaedic Centre (SWAOC) hit another major milestone this month, as it completed its 1,000th knee/hip replacement since opening at the Nightingale in March 2022.

The centre is one of only eight elective surgical hubs in the country to have been GiRFT accredited and is recognised nationally for its high clinical and operational standard. It has also expanded its services to include hindfoot and soft-tissue knee operations.

As well as SWAOC, the other services provided at the Nightingale have also been reaching important milestones and expanding their services. More than 75,000 people across Devon – including Torbay and South Devon - have now accessed these state-of-the-art facilities in the past 12 months, helping to further reduce waiting times in the region for certain procedures.

The Centre of Excellence for Eyes (CEE), which is delivering diagnostic outpatient services and cataract surgery, is now taking patients from Torbay and is also planning to expand to a five-day service, meaning more people across Devon will be able to access these services more rapidly than before.

The Devon Diagnostic Centre (DDC), which provides medical imaging services, saw more than 50,000 patients from across Devon in the past year, helping to get people diagnosed earlier and ease pressures on departments in local hospitals. The services will also be investing in new equipment to allow for additional types of procedures.

The Nightingale is an incredible asset for the region and shows what can be achieved when partners work together for the people they serve, improving the

lives of people across Devon who will benefit from these vital operations and services.

**Thanking our special friends in volunteers' week**
We are privileged to have hundreds of people who support our work and foremost among these are our amazing volunteers, including our nine fabulous League of Friends, and our Torbay Hospital Nurses' League.

We were delighted to welcome members of Ashburton, Dawlish, Newton Abbot, Paignton, Torbay and Totnes Leagues and our Nurses' League to Torbay Hospital this month to thank them for their dedicated service and to celebrate NHS75. It was wonderful to hear from them about all the work they are doing to support our teams and our services and to share ideas for how we can improve how we work together for the benefit of everyone in Torbay and South Devon.

We are truly sorry that members of Brixham, Dartmouth and Teignmouth Leagues were unable to join us – a small token of our gratitude has been shared with their members.

## 4. Chief executive engagement June

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 |
|---|---|
| • Volunteers week celebration<br>• Video blog sessions<br>• Diversity and inclusion lead<br>• League of Friends Chairs meeting<br>• Visit to general theatres | • Dame Andrea Leadsom<br>• Regional Chief Executive, NHS England (NHSE)<br>• Improvement Manager, NHSE<br>• Chief Executive, Integrated Care System Devon (ICSD)<br>• Improvement Director, ICSD<br>• Chief Finance Officer, ICSD<br>• Long Term Plan Programme Director, ICSD<br>• Chair, NHS Cornwall and Isles of Scilly<br>• Deputy Chief Executive Officer, Royal Devon University Healthcare NHSFT<br>• Chief Executive Officer, University Hospital Plymouth NHS Trust<br>• Chief Finance Officer and Deputy Chief Executive Officer, Devon Partnership NHS Trust<br>• Chief Medical Officer, LiveWell<br>• Director of Children's Services, Torbay Council |

| | |
|---|---|
| | • Chief Executive, Rowcroft Hospice<br>• Chief Executive, HealthWatch<br>• SingHealth |

**5. Local health and care economy developments**

**5.1 <u>Partner and partnership updates</u>**

**5.1.1 Integrated Care System for Devon (ICSD)**

The Integrated Care Board now meet bi-monthly – the next ICSD update for Boards will be shared with the papers for July's Board of Directors meeting.

**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 May board report, activity to promote the work of our staff and partners has included:

**Recent key media releases and responses:**

- promotion of our annual our people celebration event which recognised and celebrated all of our award winners from the past year
- opening of our new £5.4million health and wellbeing centre in Dartmouth, which brings a range of health services under one roof
- Nurses' league annual reunion event
- update on the sale of the former Dartmouth Hospital
- construction work has begun to build our new radiotherapy CT suite.

**Recent engagement on our social media channels includes (figures on reach and views relate to Facebook):**

- we celebrated international nurses' day sharing a story of Ian Cave, a relative of Florence Nightingale, who is being supported by some of our community nurses, including a nurse also named Florence.
- we announced our first Primrose award winner Teresa, a healthcare support worker on Louisa Cary ward, as our first winner of the Primrose award
- Kenyan academics visit Torbay Hospital – welcoming our visitors from Kenya who visited trusts across the peninsula to learn about our organisation and the wider NHS.
- Allied health professionals' recruitment event – promoting our recruitment event, specifically for AHPs who are studying.
- International Nurses' Day – sharing photos of lots of our colleagues as part of our celebrations for International Nurses Day.

- Mayoral visit to Castle Circus – Cllr Mandy Darling, Civic Mayor of Torbay and Cllr Steve Darling visited Castle Circus Health Centre to thank our teams based there for the care and support they deliver.
- Coronation celebrations – sharing photos of our wards and departments who organise activities and decorated to mark the coronation.
- League of Friends tea party – thanking our Torbay Hospital League of Friends for holding a fundraising afternoon tea party at Hunt's Cider.

**Development of our social media channels:**

| Channel | End of year target | As of 31 March 2021 | As of 31 May 2023 |
|---|---|---|---|
| LinkedIn | 8,000 followers | 2,878 | 6,168 followers ↑ 3,290 followers |
| Facebook | 15,000 likes | 12,141 | 13,973 ↑ 1,832 followers |
| | 15,000 followers | 12,499 | 14,999 ↑ 2,500 followers |
| Twitter | 8,000 followers | 6,801 | 7,903 followers ↑ 1,102 followers |

## 7 Recommendation

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

| **Report to Trust Board of Directors** | | | |
|---|---|---|---|
| **Report title**: Integrated Performance Report (IPR): Month 2 2023/24 (May 2023 data) | | | Meeting date: 28 June 2023 |
| **Report appendix** | M2 2023/24 IPR Dashboard of key metrics<br>M2 2023/24 IPR Focus Report | | |
| **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<br>Trust Management Group: 6 June 2023<br>Executive Director sign off: 23 June 2023<br>Finance, Performance, and Digital Committee: 26 June 2023 | | |
| **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:<br>• Review evidence of overall delivery, against national and local standard and targets<br>• Interrogate areas of risk and plans for mitigation<br>• provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator.<br><br>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** | | | |
| **Is this on the Trust's Board Assurance Framework and/or Risk Register** | | | |

Strategic objectives supported by this report:

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

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

| **Board Assurance Framework** | Yes | **Risk score** | 20 |
|---|---|---|---|
| **Risk Register** | Yes | **Risk score** | 25 |

<table>
<tr>
<td>External standards affected by this report and associated risks</td>
<td>
<table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
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<br>
This report reflects the following corporate risks:<br>
<br>
• failure to achieve key performance standards;<br>
• inability to recruit/retain staff in sufficient number/quality to maintain service provision;<br>
• failure to achieve financial plan.
</td>
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**Introduction:**

The Integrated Performance Report pulls together key metrics and performance exceptions across quality, workforce, performance, and finance.

The report highlights area of risk that have been escalated through the Integrated Service Units and System Care Group Directors. The People Committee provides governance and oversight for workforce and the Quality Assurance Committee for quality and safety metrics.

The purpose of the report is to inform the FPDC and Trust Board of areas to note and provide more granular details against key areas of interest and potential concern.

Operational narrative against key performance metrics are contained in the Chief Operating Officer's report.

**Quality Headlines:**

**Incidents**

In May 2023, one incident of severe harm and one incident of death were reported onto the national StEIS system. The severe incident was a delay in referral to the ophthalmology team and the death was of a patient who fell and sustained a sub-Dural bleed. A full investigation is underway following the Serious Incident Policy for both cases.

**Stroke**

Timely access to a dedicated Stroke Ward improves clinical outcomes for patients and offers improved quality of life outcomes. In May 2023, 27.8% of patients were admitted to the Stroke Ward within 4 hours of arrival at hospital which remains below the target of 90% but is an improvement on the April position. In May 80% of stroke patients admitted to the Stroke Ward spent 90% or more of their time on the dedicated Stroke Ward which achieved the standard of 80%; this is an improved position.

**VTE Assessment**

VTE (Venous Thromboembolism) Assessment compliance demonstrated a conformity for all in patients of 95.4% in May 2023 which is a slight deterioration from the April position.

Those areas that are not achieving the standard required are being supported by the VTE Steering Group.

**Infection, Prevention, and Control**

Bed closures saw a decrease from 217 in April 23 to 120 in May 2023. The reason for the decrease was mainly due the implementation of new national guidance on management of patients who test positive for COVID-19

**Maternity**

There were no stillbirths or fetal loses in May 2023.

The Trust were notified in May 2023 of their achievement of 10/10 for the Maternity Incentive Scheme, only seven South West Trusts achieved full compliance.

CNST (Clinical Negligence Scheme for Trusts) year 5, as well as version 3 of the Saving Babies Lives Care Bundle was published on 31st May 2023. The impact for the team and organisation will be shared at the Quality Assurance Committee and Trust Board in July 2023.

**Staffing**

The Registered Nurse fill rate for days during May was 97% which is an increase on April fill rate of 92.4%, and for night duty reported as 91% a slight decrease on the previous months fill rate of 91.3%.

The fill rate for Health care support workers for days is 105% for days, which is an increase on April figures of 103.7% and 119% for nights which is an increase on April figures of 114.0%.

**Workforce Headlines:**

**Staff sickness/absence**

The monthly sickness has decreased in May's figure of 4.46% from 5.07% in April. The preliminary annual rolling sickness absence rate is 5.29% to the end of May 2023 from 4.96% in April. Overall, the picture for 2022-23 shows improvement compared to the previous year. Sickness is reported through local ISU Governance meetings and through other local reports to help inform leads of any trends positive or negative.

**Appraisal rate**

May's Achievement Review rate increased to 78.12% from 77.87% in April. There has been a 3% increase since June 2022, so the trend is showing an upward rise.
The People directorate has developed and rolled out effective achievement review training trust wide and this training recognises that what is important is the quality of these reviews rather than the quantity completed. Appraisal information is reported through local ISU Governance meetings and through local cost centre reports so that leads are kept informed of progress.

**Turnover (excluding Junior Doctors)**

Turnover has now plateaued and in the last eight months since September 2022 has dropped significantly from 13.99% to 12.83% and in May 2023 it was the lowest it has been in the last year. The Trust's turnover rate of 12.74% for the year ending May 2023 remains within the normal tolerances of 10-14%.

As part of Our People Promise, the activities highlighted by the ICS to enhance retention are being applied to Torbay and South Devon and Turnover information is always shared through the local ISU Governance meetings.

**Mandatory Training rate**

The May **overall** rate for mandatory training figure increased slightly to 91.24% against a target of 85% and is the highest it has been for the last 12 months. Overall training compliance is constantly above the target of 85%. There are no signs of concern and the mean over the last 2 years has been at least 4% above the target.

Vacancy data will be available in next month's report.

**Performance Headlines:**

Performance against the System Operating Framework Level 4 exit criteria are summarised in the Performance Focus Report. Where the exit criteria is not being met, exception reports have been created for executive oversight and covers operational update, actions identified, and risks and issues.

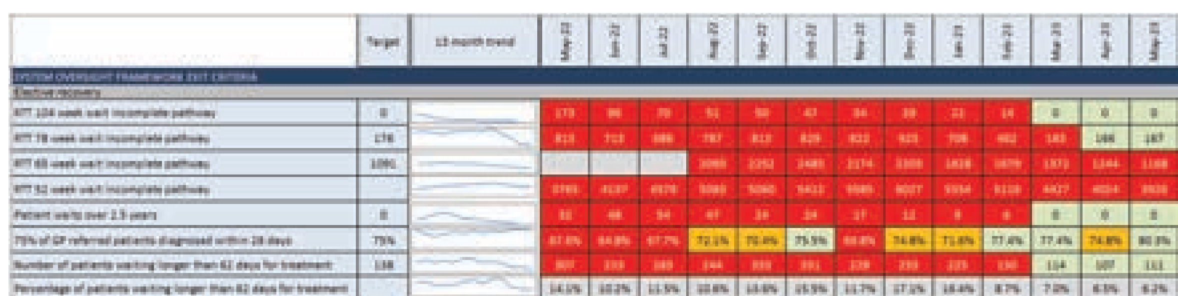
Extensive performance oversight and scrutiny with the ICB and our regulators, is in place through monthly executive meetings (System Improvement Assurance Group (SIAG)) and other key weekly groups focusing on delivery of key performance targets.

The Chief Operating Officer report provides further narrative with an update on progress and the controls in place in relation to operational delivery across the Trusts Integrated Service Units (ISU's) and Children and Family Health Devon (CFHD).

**Urgent and Emergency Care SOF 4 headlines:**

- Extensive improvement plans are in place on our key focus areas with particular attention on the exit criteria and other leading pathway changes that will make a positive contribution.
- Overall, the Trust's UEC performance was 60.8% and under operational plan trajectory of 65%.
- Ambulance delays increased in May with 72.1% of handovers over 15 minutes compared to 55.4% in April.
- The Trust has seen another month of improvement against the number of patients reported as having No Criteria To Reside (delayed discharges) achieving an average level of 6% of occupied beds.
- Operational focus remains on improving the discharges earlier in the day before noon (18.9% achieved against the 33% target), increasing the number of discharges over weekends to 80% of a normal weekday per day, and reducing length of stay.

**Elective Recovery SOF 4 headlines:**



**Elective Referral to Treatment**

- The zero 104-week patient wait target was again achieved at the end of May 2023.
- Against 78-week RTT target the Trust reported 167 breaches against a plan of 173.

**Cancer standards**

Torbay is now classified as a Tier 2 provider following a sustained period of improvements.

- 80.3% achieved against the Faster Diagnosis Cancer Standard of 75%;
- Cancer 62-day backlog – the Trust reported 111 patients (6.2%) waiting over 62 days for treatment against a Trust target threshold of 138. This is the fifth month where the percent of patients waiting longer than 62 days for treatment has reduced. Further detail can be found in the Chief Operating Officer Report.

**Diagnostics**

The Trust reported 27.7% of patients waiting longer than 6 weeks against the target of 25%.

**Adult Social Care:**

The Performance and Transformation Committee meets monthly with Council and Trust representatives. This committee covers all aspects of performance, service delivery, and financial risks; the Committee reports into the Torquay Integrated Governance Group.

**Finance headlines**

As of May-23 (Month 2), the financial performance indicated a favourable variance to plan.

Our operating income reached **£106.5m**, **£1.66m** higher compared to the projected **£104.85m** plan, reflecting a minimal variance of less than 2%. Similarly, our operating expenditure was greater than our budgeted cost, with the actual expenditure standing at **£115.96m** against the expected **£114.61m**.

The period concluded with an overall deficit of **£9.62m**, marginally better than the forecasted deficit of **£9.93m**, resulting in a positive variance of **£0.31m**.

However, it's important to note that the operating expenditure includes additional costs relating to pay award in addition to the unplanned cost pressure of **£0.16m,** due to the Junior Doctors Industrial Action. Anticipating that this cost may escalate with further industrial action expected in the coming months, close monitoring and mitigation strategies will be necessary.

The opening cash balance was **£19.77m** higher than planned. This is principally due to the March 2023 capital creditor having been higher than assumed. Capital-related

cashflow is **(£12m)** adverse, largely due to further pay down of the capital creditor. The plan assumed that this would have happened at the end of the prior year.

Creditor movements was a favourable **£11.75m**. This is primarily due to the timing of the weekly payments run, with unusually high payments of **£15.0m** having been made on the 1 June 2023. NHSE (formerly HEE) funding of **£1.4m** has also been received in advance.

# Integrated Performance Focus Report (IPR)

**June 2023: reporting period May 2023 (Month 2)**


| | | Page |
|---|---|---|
| 1. | System Oversight Framework (SOF) Introduction<br>Indicative measures<br>Accountability Framework<br>Chief Operating Officer Highlight Report<br>SOF 4 Performance Summary<br>Exception report -Urgent and Emergency Care<br>Exception report -Elective Recovery | 2<br>3<br>4<br>5<br>6<br>7<br>13 |
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*Working with you, for you*

## System Oversight Framework - Introduction

In December 2022 NHS England rated the Trust at SOF 4 (NHS System Oversight Framework) along with the wider Devon System. The Trust was previously rated as SOF 3. The levels are rated as levels 1 to 4 with SOF 4 being the highest level of oversight. This decision was reached due to our financial performance and delivery against performance targets.

Exiting SOF 4 is the key objective to achieve over the coming months. There is a draft set of exit criteria to be achieved, however, we are awaiting finalisation of these to reflect the changes in the Operational Planning Guidance for 2023/24.

In support of the performance standards relating to Elective Recovery, the Trust will have operational recovery plans at specialty level to describe the actions and target milestones that need to be delivered and monitored.

Recent support from NHSE has enabled the Trust to develop more robust delivery plans for our long wait cohorts in 2023/24.

Tier 1 performance oversight:
The Trust remains in the Tier 1 performance regime from NHS England against Referral to Treatment (RTT) long waits but has been downgraded to Tier 2 for Cancer performance following sustained improvements on our Key Lines Of Enquiry cancer standards. The weekly executive meetings with the South West region performance leads, continue to review progress and gain assurance on agreed action plans.

System Operational Framework (SOF)
Exiting SOF 4 remains the key Trust objective, therefore, the performance section of this month's IPR (Integrated Performance Report) focuses on progress against the SOF 4 exit criteria measures. Where the exit criteria are not being met, exception reports have been created for executive oversight and covers operational update, actions identified, and risks and issues.

System Operational Framework (SOF) monitoring
To support the monitoring of the exit criteria a Tableau dashboard has been created and work is on-going to finalise the data ahead of publication.

## System Oversight Framework 4 Exit Criteria – Indicative Measures

The set of exit criteria below highlights performance levels to be achieved to exit SOF 4, however, we are awaiting finalisation of these to reflect the changes in the NHS Operational Planning Guidance for 2023/24.

Each indicative measure has a target to be achieved to exit SOF 4 with local trajectories being agreed in line with operational planning submissions. The performance section of this report has been amended to reflect this focus and will build in the details of the SOF 4 exit plans, and progress against these plans and milestones, as they are agreed.

# Exit Criteria Measures

| Area | Measure |
|---|---|
| UEC | Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours) |
| | Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average over 23/24, with plan for further improvements in 24/25 |
| | Improvements in line with agreed baseline and plan, over two quarters, in total average time in ED & 12 hour breaches. (Trajectory to achieve 76% by 23/24) |
| | Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories |
| | Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 5% |
| | Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 2019 levels by end of 23/24 |
| Elective Recovery | Reduction in waits over 104 weeks and 78 weeks, inline with agreed plan, against agreed baseline |
| | Significant reduction in 65 weeks by March 2024, inline with agreed plan, against agreed baseline |
| | 75% of GP referred patients diagnosed within 28 days |
| | To exit Tier 1: The percentage of patients waiting over 62 days to start cancer treatment across the system is less than double the requirement for March 2023 (≤12.8%) and working towards achieving the national target |
| | To exit Tier 1: The weekly number of patients waiting over 62 days decreases over 4 consecutive weeks and remains stable, or improving for 2 out of 3 months for the quarter |
| Finance | There is confirmation of the underlying run rate from 2022/23 and an improvement in the actual recurrent run rate in the 2023/24 plan |
| | The 2023/24 plan shows an improvement in productivity compared to 2022/23 |
| | A system-wide shared services programme is developed that has all back office functions within scope and includes accompanying timelines and delivery plans |
| | The system delivers the financial plan for 2023/24 recurrently for two successive quarters |
| | The system delivers improvements in productivity in 2023/24 for two successive quarters |

# System Oversight Framework 4 Exit Criteria – Accountability Framework

| | **Accountability framework** | | | | | |
|---|---|---|---|---|---|---|
| **Metric:** | **Senior Responsible Officer:** | **Clinical Lead:** | **Executive Lead:** | **Reporting forum for review of performance** | **Meeting monthly trajectory** | **Meeting SOF 4 exit target** |
| **UEC 4 hour target 76% by March 2024** | System Care Group Director (SCGD) - Urgent Care | System Care Group - Medical Director (SCGMD) | Chief Operating Officer | Operational Recovery Group (ORG)<br>Trust Management Group (TMG) | No | No |
| **Ambulance handovers greater than 15 minutes** | SCGD – Urgent Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Trajectory TBC | No |
| **Over 12-hour visit time; and ED (type 1) 4-hour target** | SCGD – Urgent Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Trajectory TBC | No |
| **Increase in pre-noon patient discharges** | SCGD – Urgent Care | SCGMD | Chief Operating Officer | ORG<br>TMG | No | No |
| **Reduction in 'No criteria to reside'** | SCGD – Families community and place based | Deputy Medical Director | Chief Operating Officer | ORG<br>TMG | Yes | No |
| **Patient wait over 104 weeks and 78 weeks** | SCGD – Planned Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Yes | Yes |
| **Patient wait over 65 weeks** | SCGD – Planned Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Yes | Yes |
| **75% of GP referred patients diagnosed within 28 days** | SCGD – Planned Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Yes | Yes |
| **Cancer longer than 62-day wait** | SCGD – Planned Care | SCGMD | Chief Operating Officer | ORG<br>TMG | Yes | Yes |

# System Oversight Framework 4 Exit Criteria – Chief Operating Officer Highlight Report

| Matters of concern/key risks to escalate | Major actions commissioned/work underway |
|---|---|
| • Ongoing Industrial Action<br>• TIFF Theatre delivery of activity, recruitment of workforce.<br>• Infection outbreaks impacting on staff and bed availability<br>• Seasonal uplift in activity – specifically walk in attendances | • Establishment of Urgent and Emergency Care Board and Planned Care Board<br>• Development of space and process changes within ED for non-admitted patient performance improvement<br>• Review of Pathway 1-3 processes about to be completed by Newton Europe.<br>• Support in place from Michael Wilson and NHSE National Team |
| **Positive assurances** | **Decisions made** |
| • Planned care performance improving<br>• UEC 4hr performance above 60% and on track to improve.<br>• Management of Industrial Action and Bank Holidays resulting in lower numbers of cancellations and improved flow. | • Organisational reshaping agreed – implementation July 2023<br>• SOF4 Communications strategy agreed<br>• Updated IPC guidance |

# System Oversight Framework 4 Exit Criteria - Performance Summary

| | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA** | | | | | | | | | | | | | | | |
| Urgent and Emergency Care | | | | | | | | | | | | | | | |
| Percentage of Ambulance handovers greater than 15 minutes | | | 69.6% | 80.0% | 77.0% | 78.3% | 77.5% | 84.4% | 82.2% | 87.5% | 66.5% | 54.8% | 73.9% | 55.4% | 72.1% |
| Total average time in ED (hours/minutes) | | | 06:23 | 07:22 | 07:02 | 07:06 | 07:33 | 07:58 | 07:44 | 08:59 | 07:49 | 06:35 | 07:34 | 05:57 | 06:48 |
| ED attendances where visit time over 12 hours | 0 | | 668 | 871 | 827 | 920 | 906 | 988 | 939 | 1207 | 823 | 599 | 977 | 568 | 891 |
| UEC 4-hour target (RAG against local trajectory to national target | 76% | | 57.6% | 54.5% | 58.5% | 59.1% | 60.2% | 57.0% | 59.4% | 51.8% | 60.0% | 56.9% | 57.6% | 61.7% | 60.8% |
| % patient discharges pre-noon | 33% | | | | | | | 18.4% | 23.6% | 18.1% | 19.0% | 18.5% | 19.2% | 18.9% | 18.9% |
| Percentage of inpatients with No Criteria to Reside (acute) | <5% | | | | | 17.0% | 12.0% | 11.0% | 11.0% | 13.0% | 13.0% | 12.0% | 8.1% | 7.6% | 6.0% |

**Performance summary:** 0 out of 6 Urgent and Emergency Care trajectory targets have been met in May 2023.

**Improved performance has been seen this month in:**
- Percentage of patients with No Criteria to Reside.
- Second consecutive month over 60% for 14 months

**Performance remains the same for:**
- Percentage of patients discharged pre-noon.

**A deterioration in performance has been seen in:**
- Percentage of ambulance handovers greater than 15 minutes;
- Total average time in ED;
- ED attendances where visit time over 12 hours;
- 4-hour ED target.

| | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA** | | | | | | | | | | | | | | | |
| Elective recovery | | | | | | | | | | | | | | | |
| RTT 104 week wait incomplete pathway | 0 | | 173 | 96 | 70 | 51 | 50 | 47 | 34 | 29 | 22 | 14 | 0 | 0 | 0 |
| RTT 78 week wait incomplete pathway | 176 | | 813 | 713 | 686 | 787 | 813 | 829 | 822 | 923 | 708 | 462 | 183 | 166 | 167 |
| RTT 65 week wait incomplete pathway | 1091 | | | | | 2093 | 2252 | 2485 | 2174 | 2203 | 1828 | 1679 | 1372 | 1244 | 1168 |
| RTT 52 week wait incomplete pathway | | | 3765 | 4137 | 4578 | 5083 | 5060 | 5412 | 5585 | 6027 | 5554 | 5116 | 4427 | 4024 | 3926 |
| Patient waits over 2.5 years | 0 | | 32 | 48 | 54 | 47 | 24 | 24 | 17 | 12 | 9 | 6 | 0 | 0 | 0 |
| 75% of GP referred patients diagnosed within 28 days | 75% | | 67.6% | 64.8% | 67.7% | 72.1% | 70.4% | 75.5% | 69.8% | 74.8% | 71.6% | 77.4% | 77.4% | 74.8% | 80.3% |
| Number of patients waiting longer than 62 days for treatment | 138 | | 307 | 233 | 283 | 244 | 333 | 331 | 229 | 253 | 225 | 130 | 114 | 107 | 111 |
| Percentage of patients waiting longer than 62 days for treatment | | | 14.1% | 10.2% | 11.5% | 10.6% | 13.6% | 15.5% | 11.7% | 17.1% | 16.4% | 8.7% | 7.0% | 6.5% | 6.2% |

**Performance Summary:** 3 of 4 Elective Recovery exit criteria targets have been met in May 2023.

**Improved performance has been seen this month in:**
- Number of patients waiting 65 weeks for treatment;
- Number of patients waiting 52 weeks for treatment;
- 75% of GP referred patients receiving a cancer diagnosis within 28 days;
- Percentage of patients waiting longer than 62 days for treatment

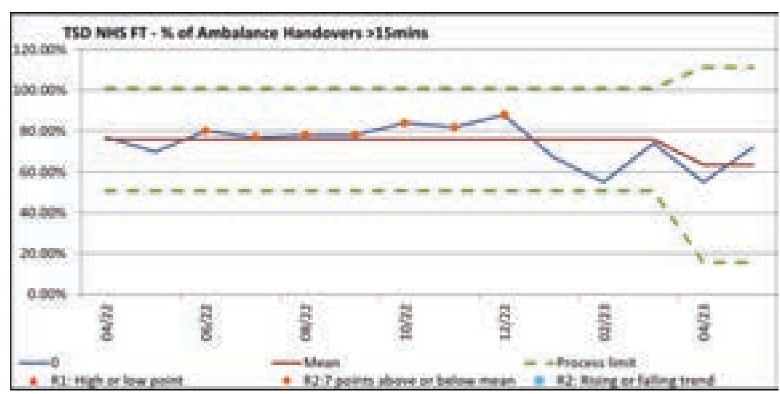
**A deterioration in performance has been seen in:**
- Number of patients waiting 78 weeks for treatment.

**Performance remains the same for:**
- Number of patients waiting 104 weeks for treatment;
- Patients waiting over 2.5 years.

# **Exception report: Ambulance Handovers over 15 minutes:** SOF 4 Exit Criteria - Urgent and Emergency Care

## Performance

Ambulance handover delays increased in May as activity to the Emergency Department grew by 8.5%.
May also saw three bank holidays and a period of industrial action all impacting ambulance handovers.

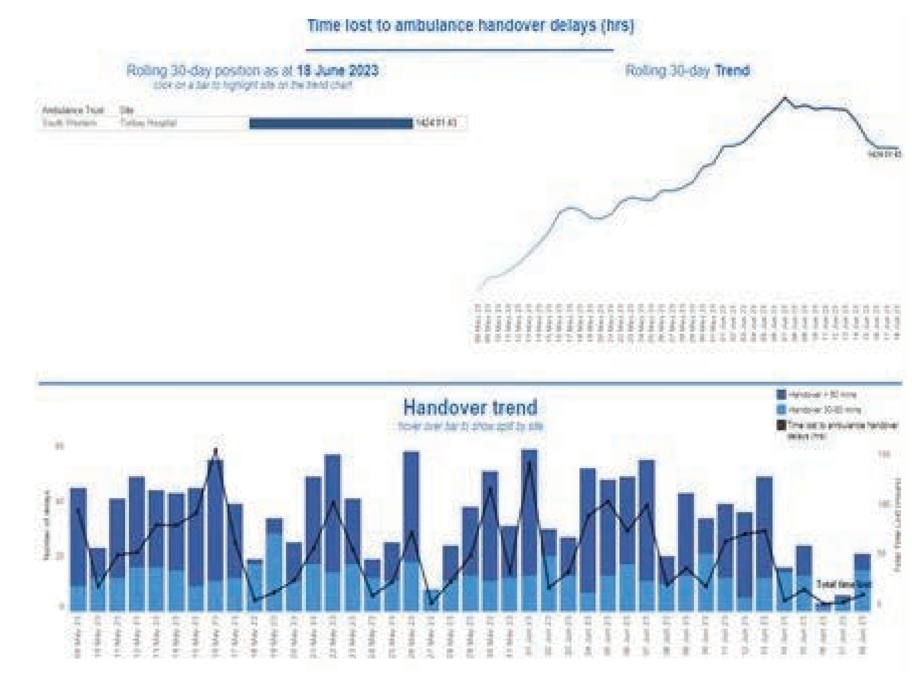



Rolling 30-day position as at **18 June 2023**
*click on a bar to highlight site on the trend chart*

| Ambulance Trust | Site | |
|---|---|---|
| South Western | Derriford Hospital | 3706:40:22 |
| South Western | Gloucestershire Royal Hospital | 1706:20:59 |
| South Western | Royal Cornwall Hospital (treliske) | 1542:55:20 |
| South Western | Torbay Hospital | 1424:01:43 |
| South Western | Royal United Hospital | 1317:06:04 |
| South Western | The Great Western Hospital | 1058:34:19 |
| South Western | Bristol Royal Infirmary | 675:19:08 |
| South Western | Royal Devon & Exeter Hospital (w... | 662:09:45 |
| South Central | Queen Alexandra Hospital | 532:59:49 |
| South Western | Southmead Hospital | 367:11:31 |
| South Western | Royal Bournemouth Hospital | 342:06:24 |
| South East Coast | Royal Sussex County Hospital | 286:03:45 |
| South Western | Poole Hospital | 258:49:06 |
| South Western | Weston General Hospital | 236:15:20 |
| South Western | North Devon District Hospital | 185:41:01 |

## Operational update

Despite our improvements in reducing 60-minute breaches, ambulance handover delays increased in May. During the month, three bank holidays and a period of industrial action, plus an uplift of 8.5% general attendance to the Emergency Department, impacted on performance.
A combination of high occupancy and flow out of the department were the contributing factors adding to the delays.




## Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance and improving performance by:

1. Increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

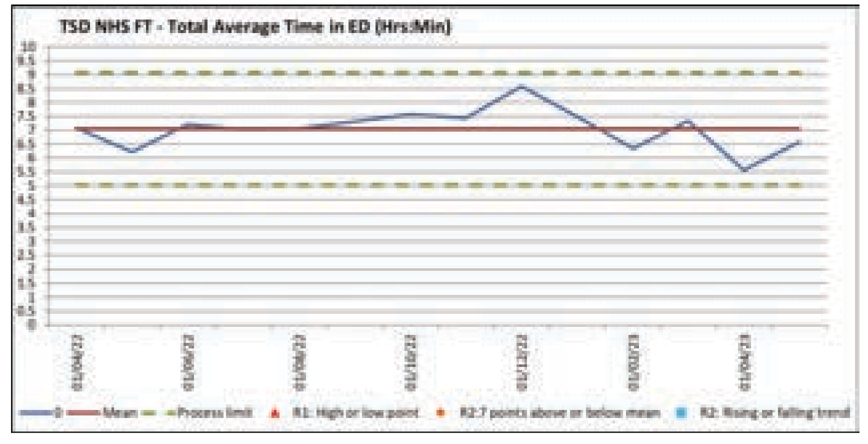
## Risks/issues

- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

# **Exception report: Total average time in ED:** SOF 4 Exit Criteria - Urgent and Emergency Care

## Performance

May saw an increase in the total average time in the Emergency Department to 06.48hours from 05.57hours the previous month.




## Operational update

During May, three bank holidays, a period of industrial action plus a daily uplift in attendances of 209 to the Emergency Department impacted on average time in the Department.

Higher attendances contributed to longer waits, specifically in delays to see patients in the waiting area, where space is at a premium to manage patient flow.

The bank holiday and industrial action likewise impact on general bed flow leading to higher occupancy levels in the emergency department and increased waits for onward beds.

## Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance and improving performance by:

1. Increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

In addition to the above, the following actions are underway:

- Use of the ED escalation area 11 beds - options paper for agreement to improve flow – June 2023
- Virtual Ward – complete on-site mobilisation – data reporting to be implemented
- Focus on quick win non-admitted pathways – ED improvement week w/c 26/6/2023

## Risks/issues

- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

# **Exception report: Over 12-hour visit time:** SOF 4 Exit Criteria - Urgent and Emergency Care

## Performance

May 12 hour visit time performance mirrored the ambulance delays and total average time in ED with an increase in numbers, as activity to the Emergency Department grew by 8.5%. May also saw three bank holidays and a period of industrial action all impacting ambulance handovers.

## Operational update

During May three bank holidays, a period of industrial action plus a daily uplift in attendances of 209 to the emergency department impacted on 12hr performance.

Higher attendances contributed generally to longer waits.

These waits were compounded by bank holidays and industrial action impacting on general bed flow leading to higher occupancy levels in the Emergency Department and increased waits for onward beds.

## Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance and improving performance by:

1. Increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

In addition to the above, the following actions are underway:

- ED escalation area 11 beds - options paper for agreement to improve flow – June 23
- Virtual Ward – complete on site mobilisation – data reporting to be implemented
- Further utilisation of the discharge lounge, and early identification of tomorrows discharges (SWIFT, Nerve Centre and Portal alignment)

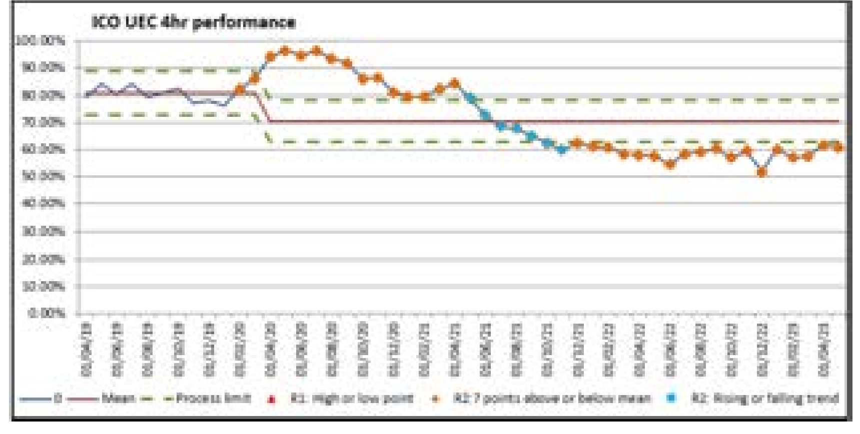
## Risks/issues

- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

# **Exception report: 4-hour ED target:** SOF 4 Exit Criteria - Urgent and Emergency Care

## Performance

ED Type 1 performance 40.46%
ICO Performance 60.83%




## Operational update

- Daily demand to the Emergency Department (ED) rose from 199.2 in April to 209.2 in May. Overall attendances increased from 5977 to 6488. We achieved 40.46% against our ED 4-hour target.

- Our type 3 demand (UTC and MIU) increased to 3521 up from 3002 in April . We achieved 98.35% against our Type 3 4-hour target an increase in performance from 97.87 in April.

- ICO attendances saw an increase in month of 11.5% to 10009
- Overall, our UEC performance was 60.83% down from 61.74% in April.

- This is the second consecutive month where ICO (Integrated Care Organisation) performance is above 60% since February 2022. Performance for June is currently at a level higher than any month since December 2021.

Comparing previous years at this point in the season daily Type 1 Emergency Department activity at 209.2 is up from 169.4 in 2022 and 196.6 in 2021.

This pattern is mirrored for Type 3 daily activity at 113 attendances for 2023 compared to 87.9 for 2022 and 87.2 for 2023.

## Actions to complete next month

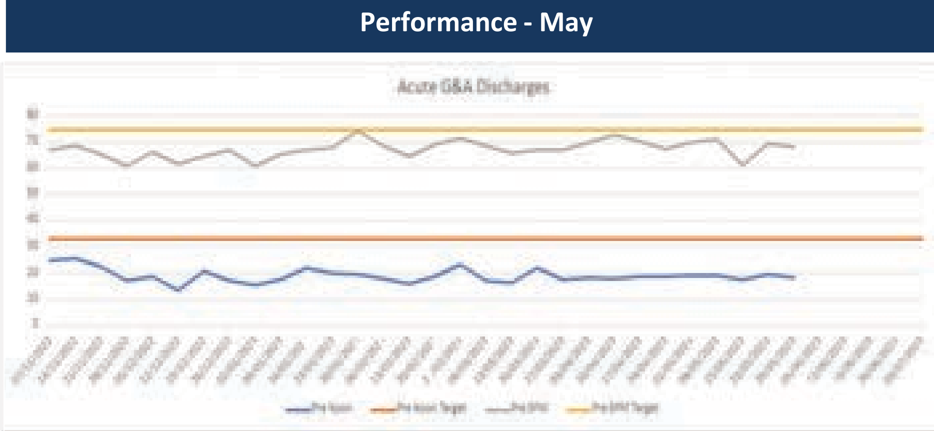
- Urgent Emergency Care Board and 3 workstreams progression– Internal professional standards and measurement to be agreed
- ED Space and processes - options paper for agreement to improve flow - June 2023
- Virtual Ward – complete on-site mobilisation – data reporting to be implemented
- Progress UEC funding and implement the plan
- Focus on quick win non admitted pathways – ED improvement 'Focus' week w/c 26/6/2023

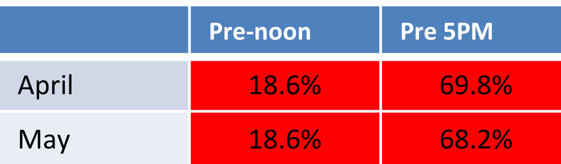
## Risks/issues

- Further infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

# **Exception report: Percent of pre-noon discharges:** SOF 4 Exit Criteria - Urgent and Emergency Care

## Performance - May



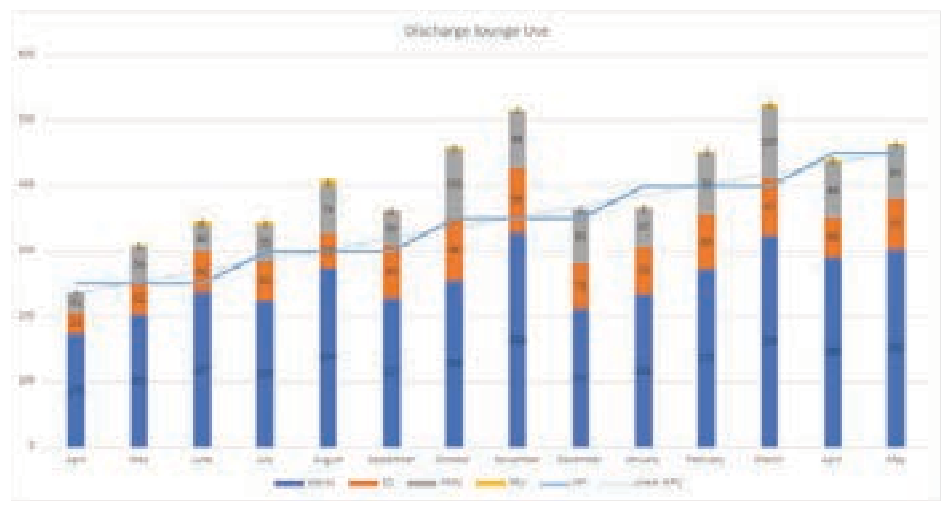



| | Pre-noon | Pre 5PM |
|---|---|---|
| April | 18.6% | 69.8% |
| May | 18.6% | 68.2% |

We saw a marginal improvement in our overall general and acute discharges in May totalling 1697. On a number of occasions, we have achieved our pre 5.00 p.m. discharge target but have seen a minor decrease in our average performance. The Flow and Ward Improvement Group (Subgroup to UEC Board) seek to continue to drive this improvement, with a focus on pre-noon, with workstreams to maintain and improve this position and our patient experience.

## Operational update

The Discharge Lounge (DCL) remains helpful in generating timely ward capacity. But we continue to use the lounge as an escalation area overnight, in **May it was opened for 17 nights**. We know this is impacting our pre-noon and 5.00 p.m. discharges.



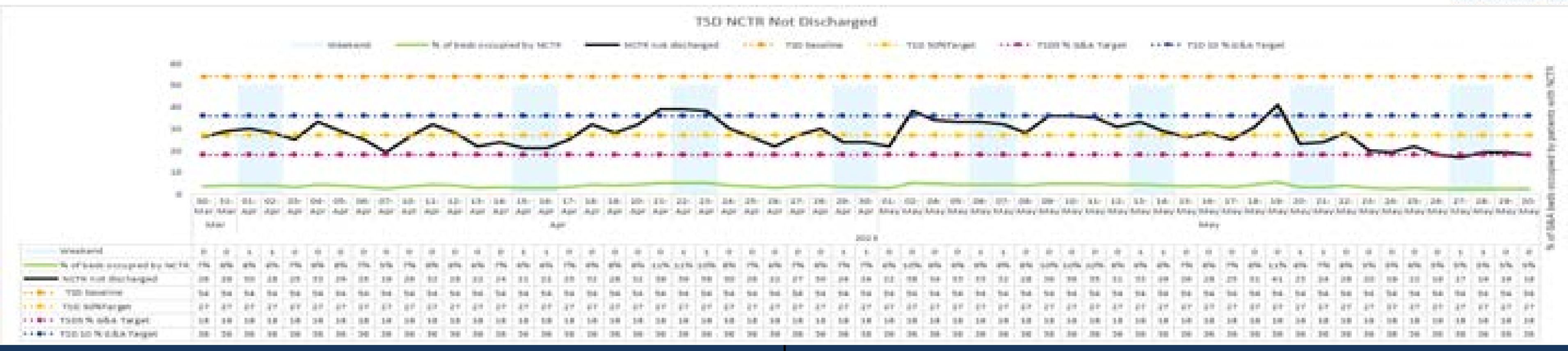
## Actions to complete next month

- Secure UEC funding - winter uplift of workforce in discharge lounge.
- Finalise workstream for Ward and Flow Improvement Group.
- Ward Nurse Flow Training Programme to start end of June.
- Develop learning from industrial action successes – specifically overnight confirmation of tomorrows discharges, Transport, and Care Planning Summaries.
- Pre-noon discharge comms drive.
- Home for lunch.

## Risks/issues

- Further infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Consistent additional staffing support to the discharge team at weekends and senior cover

# **Exception report: No criteria to reside:** SOF 4 Exit Criteria - Urgent and Emergency Care




## Performance - May

The average number of patients with No Criteria To Reside (NCTR) has been maintained in May. **Achieving 5% for 8 days in May.** We continue to have the lowest NCTR across the ICB.

Percent of patients with No Criteria to Reside - ICO

| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Performance | | | | 17.0% | 12.0% | 11.0% | 11.0% | 13.0% | 13.0% | 12.0% | 8.1% | 7.6% | 6.0% |
| Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |



## Operational update

Key actions that have supported the improvement in NCTR

- Trusted placement assessor.
- Occupational therapy in reach model – recruitment of second post.
- Flexible team and social care services
- Process review of Discharge to Assess (D2A) at a senior level to increase capacity and risk.
- Lead DISCO now attending NCTR meeting and taking actions to improve flow and validate patients converted to CTR on day of discharge
- Job description review of Lead DISCO to move into an operational manager for inpatient - awaiting AFC process to be completed.
- Discharge Hub is competing D2A visits to support discharge when locality lack capacity to meet demand.
- UEC workstreams to be confirmed to include scoping JETS and McCullum delivery model.

## Actions to complete next month

- Addressing the influx of referrals on Fridays leading into the weekend
- Internal audit of the processes of Discharge Team - scoping improvements
- Review of pre-referral patients to the hub.

## Risks/issues

- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action linked to the bank holidays

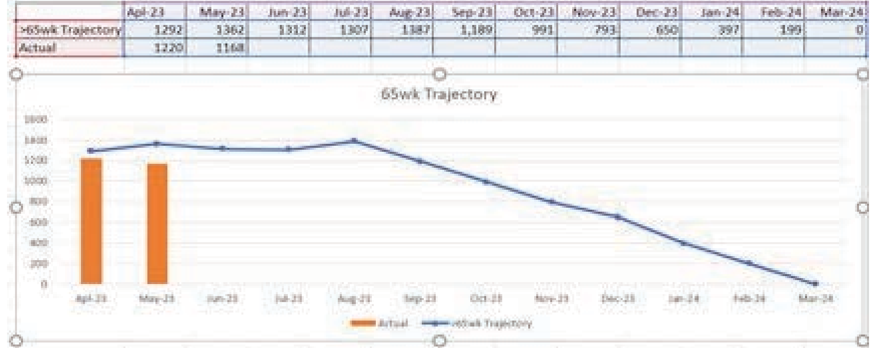
# **Exception report: 65 Week Clearance:** SOF 4 Exit Criteria – Elective Recovery

## Performance

The Trust has reported a reduction in the number of 65-week waiters in recent months.

The updated predicted position for March 2024 is a reduction in 65-week waits from the end of March position of 1,365 to 0.

May performance was 1,168 against a target of 1,362.



| | Apl-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| >65wk Trajectory | 1292 | 1362 | 1312 | 1307 | 1387 | 1,189 | 991 | 793 | 650 | 397 | 199 | 0 |
| Actual | 1220 | 1168 | | | | | | | | | | |



## Operational update

Our position has been reviewed further in June as follows:

The improved prediction is delivered across both our admitted and non-admitted waiting lists and is driven by improved productivity and efficiency implementation and maintaining or increasing the levels of insourcing activities procured in Q4 of last year.

Demand and capacity work supported by NHSE team has provided further assurance against this improved forecast.

## Actions to complete next month

Through June we will continue to build on the work done by the NHSE team to provide assurance against all our specialties, particularly where we believe there are delivery risks for outpatient activities, or the service is considered “fragile”. Our plans for our at-risk specialties, include increasing insourcing activities in Gynaecology, ENT and Oral surgery.

Enhanced reporting (Tableau based) of the 65-week cohort will be made available in June and will underpin the discipline and control of our long wait clearance plans

## Risks/issues

Delivery of the revised plans is dependent on the successful continuation and growth in our use of the Independent Sector. This is not a model the Trust considerers to be financially sustainable in the long term. Plans to be more self-sufficient within the Devon System are in discussion.

Managing staff workloads and engagement in delivery of the plan is important and remains the biggest risk to delivery of the 65-week plan.

# Quality and Safety Indicators

| Key | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ↑ = Performance improved from previous month | | ↓ = Performance deteriorated from previous month | | ↔ = No change | | | | | |
| (red) | Not achieved | (amber) | Under-achieved | (green) | Achieved | (grey) | No target set | (white) | Data not available |

| Indicator | Status | Trend |
|---|---|---|
| Reported Incidents – Severe (<6) | Achieved | ↔ |
| Reported Incidents – Death (<1) | Not achieved | ↓ |
| Medication errors resulting in moderate harm (<1) | Not achieved | ↓ |
| Medication errors - Total reported incidents (No target set) | No target set | |
| Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears) (9 per year) | Achieved | ↑ |
| Never Events (<1) | Achieved | ↔ |
| Strategic Executive Information System (STEIS) (<1) | Not achieved | ↓ |
| QUEST (Quality Effectiveness Safety Trigger Tool – red rated areas (<1) | Not achieved | ↔ |
| Formal complaints - Number received (<60) | Achieved | ↓ |
| VTE - Risk Assessment on Admission (>95%) (Acute) | Achieved | ↓ |
| Hospital standardised mortality rate (HSMR) (<100) | Not achieved | ↑ |
| Safer Staffing - ICO – Daytime (90% - 110%) | Achieved | ↑ |
| Safer Staffing - ICO – Nighttime (90% - 110%) | Achieved | ↓ |
| Infection Control - Bed Closures - (Acute)(<100) | Under-achieved | ↑ |
| Hand Hygiene (>95%) | Under-achieved | ↑ |
| Number of Clostridium Difficile cases (COHA+HOHA) | Not achieved | ↓ |
| Fracture Neck Of Femur - Time to Theatre <36 hours (>90%) | Not achieved | ↓ |
| Stroke patients spending 90% of time on a stroke ward (>80%) | Achieved | ↑ |
| Mixed sex accommodation breaches (0) | Achieved | ↔ |

## Quality and Patient Safety Summary

**Incidents**
In May 2023, one incident of severe harm and one incident of death were reported onto the national StEIS (Strategic Executive Information system). The severe incident was a delay in referral to the ophthalmology team and the death was of a patient who fell and sustained a sub-Dural bleed.
A full investigation following the Serious Incident Framework for both cases is being undertaken.

**Stroke**
In May 2023, 27.8% of patients were admitted to the Stroke Ward within 4 hours of arrival at hospital which remains below the target of 90%. This is an improvement on the April position which was 22.2% . The Trust performance around the percentage of time spent on the Stroke Ward has significantly improved with full compliance against the standard of 80% of stroke patients spending 90% of their stay on a stroke ward.

**VTE (Venous Thromboembolism) Assessment**
VTE assessment compliance demonstrated a conformity for all in patients of 95.4% in May 2023 which is a slight deterioration from the April position. Those areas that are not achieving the standard required, are being supported by the VTE Steering Group.

**Infection, Prevention, and Control:**
Bed closures saw a decrease from 217 in April 23 to 120 in May 2023. The reason for the decrease was mainly the change in national guidance for patients who test positive for COVID-19. Management of these continue to follow IPC (Infection Prevention and Control) guidelines and Public Health England guidance.

**Maternity**
There were no stillbirths or fetal loses in May 2023. Only 7 South West Trust's achieved full compliance.
CNST(Clinical Negligence Scheme for Trusts) Year 5, as well as Version 3 of the Saving Babies Lives Care Bundle was published on 31st May 2023. The impact for the team and organisation will be shared at the Quality Assurance Committee and Trust Board in July 2023.

**Safer Staffing**
The Registered Nurse fill rate for days during May was 97% which is an increase on April fill rate of 92.4%, and for night duty reported as 91% a slight decrease on the previous months fill rate of 91.3%.
The fill rate for Health care support workers for days is 105% for days, which is an increase on April figures of 103.7% and 119% for nights which is an increase on April figures of 114.0%.

# CQC update 2021 and 2020 Action Plans

**2020 CQC inspection**

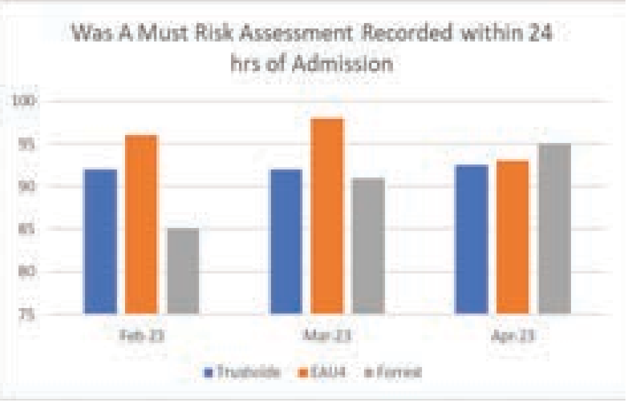
The Quality Improvement Action Plan arising from the 2020 CQC inspection is nearing completion, and all closed actions continue to have oversight through the Integrated Service Units. The Compliance Assurance Group (CQC CAG) have controls in place to ensure the actions are monitored. The Trust has one remaining Must Do action regarding the Medical Care Staff appraisal achievement rate. The Trust position in May 2023 remains at 79%.
The People Directorate have created a two-phase recovery plan with improvement trajectories to ensure the 85% target is achieved and sustained. This includes clear expectations as set out in the Peoples Promise, effective rollout of appraisal training and a transition to electronic records.

**2021 CQC Focused Inspection – Quality Improvements**

The daily five patient risk assessment audits continue to be recorded electronically and the results viewed in real time. The audit covers 43 questions across several assessments and daily, weekly, and monthly compliance reports are generated. MUST risk assessment was the most consistently completed within the 24-hour time standard with an improved compliance rate of 93%.

**April 2023**

- ✓ Audit results report Trust wide nutritional risk assessments completed within 24 hours have improved in May 2023 with a Trust position of 93%.
  It is recognised that there is a variable position on timeliness of the undertaking of patient risk assessments.
- ✓ Forrest Ward continues its improvement journey and in May recorded 93%.
- ✓ EAU4 recorded 99% compliance which is an improved position.




**May CQC Core Service Inspection**

- ✓ 24th and 25th May we welcomed the CQC as part of the Well Led inspection to review at
- ✓ least one core service. They visited medical wards, the Emergency Department and Outpatients' Departments
- ✓ A further inspection of another core service is taking place before the Well led visit, likely to be week of 19th June 2023.
- ✓ There were no immediate safety concerns highlighted during the visit and a formal feedback letter was received following the inspection. This letter does not replace the formal report but was a helpful insight into the visit.

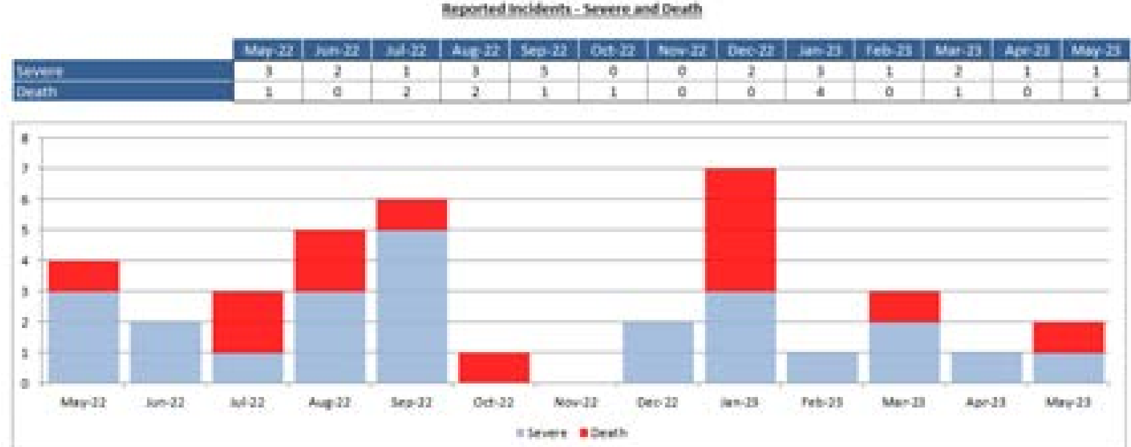
This included:

- The use of patient dayrooms in the Health Care for Older People Wards could be optimised for patient activities
- Privacy and Dignity could be strengthened in some areas. This includes patient information on IT screens.
- Quality of MCA's could be improved upon
- Outpatient department footprint was confusing for patients and visitors

**Preparations for the Well Led visit**

- ✓ Due to the Junior Doctor industrial action, the dates for the well led inspection were changed to 12th and 13th July 2023.
- ✓ Timetable for 1:1 interviews and focus groups is being rearranged for those dates.
- ✓ Information packs and bundles are being issued to those individuals who have interviews booked.

# Quality and Safety exception reports – reported incidents / HSMR




| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Severe | 3 | 2 | 1 | 3 | 5 | 0 | 0 | 2 | 3 | 1 | 2 | 1 | 1 |
| Death | 1 | 0 | 2 | 2 | 1 | 1 | 0 | 0 | 4 | 0 | 1 | 0 | 1 |

In May 2023, one incident of severe harm and one death reported onto the national StEIS system.

The incident resulting in death was an unwitnessed patient fall resulting in a subdural bleed.

The severe incident was a delay in referral to the ophthalmology team and subsequent treatment resulting in harm to the patient.

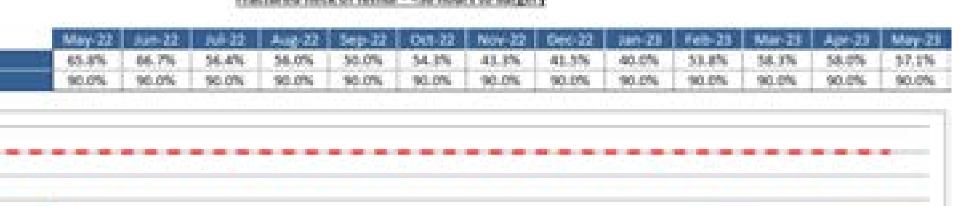
| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HSMR | 117.4 | 117 | 115.1 | 114.7 | 113.4 | 111 | 109.9 | 111.5 | 107.1 | 105.5 | n/a | n/a | n/a |
| National benchmark | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

The HSMR is measured from the mortality arising from a standardised group of 56 diagnosis.
This data is always three months in arrears due to bench marking so data is expected next month.
Work continues to focus on understanding our local population in relation to;

- Age
- Deprivation

Using our local population data the increase in HSMR data over the last two years is broadly in line with the trend of increase as seen by our regional peers.

# Quality and Safety exception report – fractured neck of femur time to surgery / VTE



**Fractured neck of femur - <36 hours to surgery**

| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % <36 hours to surgery | 65.8% | 66.7% | 56.4% | 56.0% | 50.0% | 54.3% | 43.3% | 41.5% | 40.0% | 53.8% | 58.3% | 58.0% | 57.1% |
| Target | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |

57.1% of patients had access to theatre within the recommended time frame in May 2023 against a target of 90%.

The monthly Hip Fracture Governance meetings are now in place and running frequently to monitor and manage compliance.

Other actions continue such as;

- a commitment to ringfence trauma beds;
- close working with the Emergency Department and SWAST (South West Ambulance Service Trust) to ensure early x-rays and confirmation of fractures.

**Acute VTE risk assessment on admission**

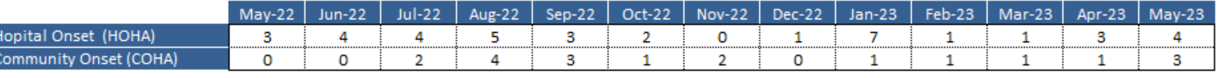
| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VTE Numerator | 5170 | 4942 | 5007 | 5255 | 5102 | 5433 | 5521 | 4896 | 5631 | 5437 | 6050 | 5152 | 5104 |
| VTE Denominator | 5766 | 5493 | 5452 | 5612 | 5505 | 5737 | 5847 | 5210 | 5894 | 5669 | 6267 | 5349 | 5349 |
| VTE Performance (Acute) | 89.7% | 90.0% | 91.8% | 93.6% | 92.7% | 94.7% | 94.4% | 94.0% | 95.5% | 95.9% | 96.5% | 96.3% | 95.4% |
| 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% |

VTE assessment

- VTE assessment audit achieved 95.4% in May, this is a slight deterioration on April's position.
- Those areas that are not achieving the standard required are being identified and supported by the VTE Steering Group.
- One area has allocated consultant support for increased surveillance.
- 13 VTE incidents reported in May which is comparable with previous months.
- Work is underway to benchmark with other organisations.

# Quality and Safety exception report - infection control

**Number of Clostridium Difficile cases**

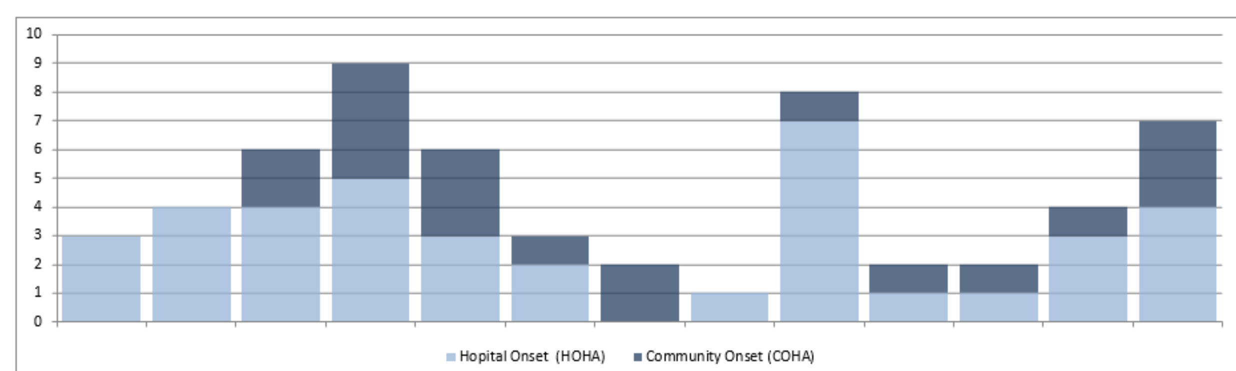


| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hopital Onset (HOHA) | 3 | 4 | 4 | 5 | 3 | 2 | 0 | 1 | 7 | 1 | 1 | 3 | 4 |
| Community Onset (COHA) | 0 | 0 | 2 | 4 | 3 | 1 | 2 | 0 | 1 | 1 | 1 | 1 | 3 |

In May, 7 cases of Clostridium Difficile were reported.

Two of the cases were on the same ward so a deep cleaning programme was undertaken.

There are no clinical areas that are causing practice concerns.




**Infection control - Bed days lost (Acute)**

| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bed closures | 12 | 130 | 84 | 36 | 132 | 42 | 156 | 786 | 339 | 254 | 164 | 217 | 120 |

Bed closures decreased from 217 in April to 120 in May 23.
The decrease was mainly due to the implementation of new national guidance on management of COVID positive patients.

There has also been a decrease in diarrhoea and vomiting closures.

Management of these bed closures have followed Infection, Prevention and Control guidelines and Public Health England guidance.

# Quality and Safety exception report – stroke care

Stroke

| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 90+% of time on stroke ward | 67.6% | 34.1% | 66.7% | 59.3% | 54.8% | 55.0% | 75.9% | 28.0% | 54.5% | 67.4% | 70.7% | 63.0% | 80.0% |
| 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% |



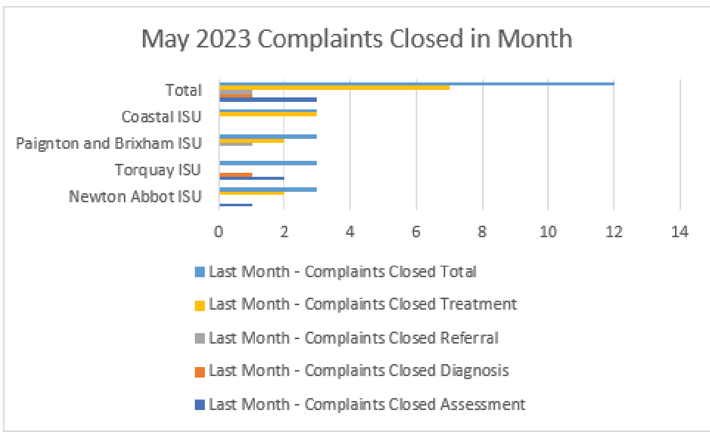
**Time critical stroke standards**

- 80% of patients spent more than 90% of their stay on the stroke unit which is a significantly improved position
- 27.8% of patients were admitted to the stroke unit with 4 hours of admission; this metric has seen a slight improvement this month;
- 100% of patients received a nutrition screen and a continence plan within 12 hours;
- 65.5% of patients received a scan within one hour;
- 98.2% of patients received a scan within 12 hours
- 83.6% saw a stroke nurse within 24 hours.

**Stroke performance governance and oversight**

Actions identified from a review of the latest SSNAP data will be added to the Stroke Improvement Plan and managed via the Stroke Governance and SSNAP meetings.
There has been a change in the chair of the Stroke Integrated Service Delivery Network and discussions have started to look at networked solutions to out of hours support for thrombolysis decision support.

# Total Number of Complaints and PAL's contacts during May 2023

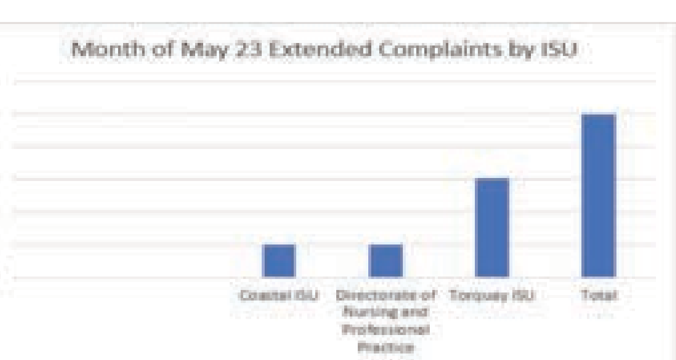



In the month of May, 12 complaints where closed, which included three from Coastal, P+B, Torquay and Newton Abbot.

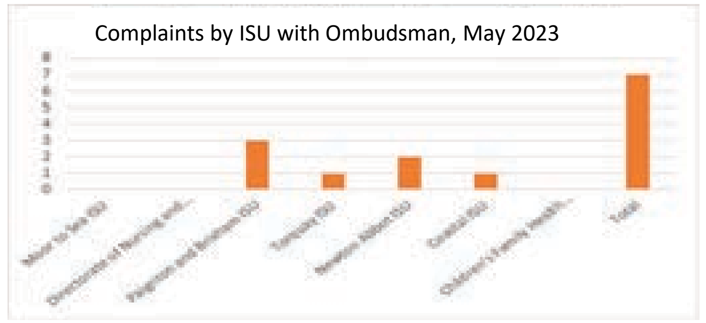
The largest theme related to complaints around

- treatment, which includes access to treatment,
- delays in treatment.

This is highest in Coastal due to the delay in surgery because of the impact COVID has had on the surgical pathway.




In May, 5 complaints where extended due to their complexity and the need for extensive investigations.

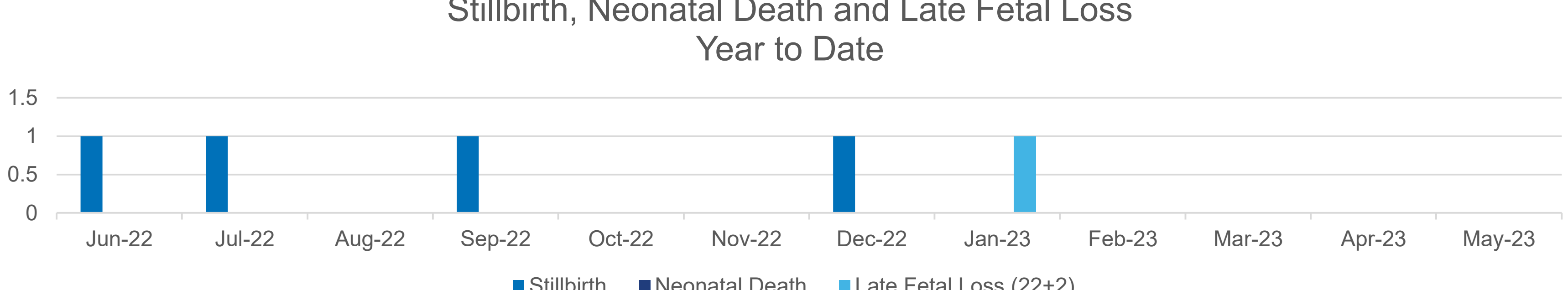



For the month of May 2023, seven complaints were active/ongoing with the Ombudsman.

Not all these referrals will be investigated or upheld. The Trust is waiting for reviews and subsequent updates from the Ombudsman.

# Quality and Safety- Perinatal Clinical Quality Surveillance May 2023

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.




The Trust had no perinatal deaths in May; there was also no new referrals this month to Healthcare Safety Investigation Branch.

| | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | April | May | Running Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of women booked for continuity of carer | | 33.5%* | 50.2%* | 50.9% | 54.9% | 52.2% | 49.7% | 61.0% | 62.1% | 64.8% | 74.4% | 63.3% | 59.3% | |
| Number of Stillbirths | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 4 | |
| % Robson Group 1 | 22.9% | 24.1% | 40.9% | 37.5% | 12.0% | 22.9% | 12.0% | 19.4% | 0.0% | 26.9% | 5.6% | 17.6% | 20.2% | |
| % Robson Group 2 | 40.0% | 45.5% | 26.1% | 48.3% | 38.2% | 36.4% | 36.4% | 42.9% | 42.9% | 18.5% | 37.0% | 22.2% | 36.2% | |
| % Robson Group 5 | * | * | * | 90.9% | 57.1% | 90.5% | 90.9% | 88.9% | 88.9% | 87.5% | 75.0% | 76.5% | 82.9% | * data not accurate |
| % Breastfeeding at Delivery | * | * | * | 70.8% | 63.9% | 64.7% | 63.0% | 63.1% | 71.8% | 71.0% | 67.1% | 71.7% | 67.5% | concerns re data accuracy |

- Reporting from our new IT system is slowly improving. However, there is still ongoing work as part of the Trust InView project that is limited by the Trust's engineering and analytical resources. This will protract the ability to provide all required Secondary Uses Service (SUS) data fields to ICB (Integrated Care Board). There has been a resolution in the submission of some missing fields for the Maternity Services Data Set which could have impacted on future CNST submissions
- The Trust were notified in May 2023 of their achievement of 10/10 for the Maternity Incentive Scheme ( CNST) They will receive in full the rebate payment, as well as a proportion of the monies not paid out to the Trust's that did not achieve 10/10. Only 7 SW Trusts achieved full compliance.
- CNST year 5 as well as version 3 of the Saving Babies Lives Care Bundle was published on 31st May 2023. The impact for the team and organisation will be shared at the Quality Assurance Committee and Trust Board in July 2023.

# Workforce Status

## Performance exceptions and actions

**Staff sickness/absence: RED for 12 months and RED for current month**
The monthly sickness has decreased in May's figure of 4.46% from 5.07% in April. The preliminary annual rolling sickness absence rate is 5.29% to the end of May 2023 from 4.96% in April. Overall, the picture for 2022-23 shows improvement compared to the previous year. Sickness is reported through local ISU Governance meetings and through other local reports to help inform leads of any trends positive or negative.

**Appraisal rate**: **Red**
May's Achievement Review rate increased to 78.12% from 77.87% in April. There has been a 3% increase since June 2022, so the trend is showing an upward rise.
The People directorate has developed and rolled out effective achievement review training trust wide and this training recognises that what is important is the quality of these reviews rather than the quantity completed. Appraisal information is reported through local ISU Governance meetings and through local cost centre reports so that leads are kept informed of progress.

**Turnover (excluding Junior Doctors)**: **GREEN**
Turnover has now plateaued and in the last eight months since Sept 22 has dropped significantly from 13.99% to 12.83% and in May 2023 it was the lowest it has been in the last year. The Trust's turnover rate of 12.74% for the year ending May 2023 remains within the normal tolerances of 10-14%. As part of Our People Promise, the activities highlighted by the ICS to enhance retention are being applied to Torbay and South Devon and turnover information is always shared through the local ISU Governance meetings.

**Mandatory Training rate**: **GREEN**
The May **overall** rate for mandatory training figure increased slightly to 91.24% against a target of 85% and is the highest it has been for the last 12 months. Overall training compliance is constantly above the target of 85%. There are no signs of concern and the mean over the last 2 years has been at least 4% above the target.

Vacancy data will be available in next month's report.

# Workforce

| Indicator | Target | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Month Sickness % | 4% | 4.83% | 6.25% | 4.77% | 4.90% | 5.86% | 5.39% | 6.54% | 5.26% | 4.59% | 4.63% | 5.07% | 4.46% | |
| 12 Mth Rolling Sickness % | 4% | 5.62% | 5.63% | 5.72% | 5.74% | 5.71% | 5.69% | 5.76% | 5.69% | 5.58% | 5.62% | 4.96% | 5.29% | |
| Achievement Rate % | 90% | 75.24% | 77.02% | 78.03% | 75.77% | 76.61% | 77.96% | 76.70% | 77.68% | 76.71% | 76.87% | 77.87% | 78.12% | |
| Labour Turnover Rate | 10-14% | 13.67% | 13.79% | 13.82% | 13.88% | 13.66% | 13.74% | 13.48% | 13.33% | 13.09% | 12.85% | 12.92% | 12.74% | |
| Overall Training % | 85% | 90.10% | 89.73% | 89.15% | 88.70% | 88.65% | 89.10% | 89.70% | 89.94% | 90.09% | 90.45% | 90.72% | 91.24% | |
| Nuring Staff Average % Day Fill Rate- Nurses | | 96% | 94% | 94% | 96% | 99% | 99% | 92% | 92% | 91% | 93% | 92% | 96% | |
| Nuring Staff Average % Night Fill Rate- Nurses | | 88% | 86% | 86% | 86% | 89% | 86% | 87% | 88% | 87% | 88% | 91% | 90% | |
| Safer Staffing- Overall CHPPD | | 7.55 | 7.48 | 7.59 | 7.53 | 7.72 | 7.75 | 7.54 | 7.72 | 7.83 | 7.75 | 7.9 | 8.05 | |

A new dashboard report separated by ISU has been produced for this months People Committee meeting and in future the risks and mitigations discussed and highlighted at the meeting will form as part of this report. This will highlight specific Care Groups/ISU's of where the risk areas are and what is being actioned to reduce the risks.

## Safer Staffing – Planned versus Actual

- The Registered Nurse fill rate for days during May was 97% which is an increase on April fill rate of 92.4%, and for night duty reported as 91% a slight decrease on the previous months fill rate of 91.3%.
- The fill rate for Health Care Support Workers (HCSW) for days is 105% for days, which is an increase on April figures of 103.7% and 119% for nights which is an increase on April figures of 114.0%.
- The increase in fill rate for Health Care Support Workers at night is to mitigate any risks associated with the Registered Nurse fill rate.

May-23

| Ward | Day | | | | | | Night | | | | | | Total Patients | Day | | | Night | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | Nursing Associates | | Care Staff | | RN / RM | | Nursing Associates | | 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 | | Average fill rate - registered nurses/mid wives (%) | Average fill rate - nursing associates (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/mid wives (%) | Average fill rate - nursing associates (%) | Average fill rate - care staff (%) |
| Ainslie | 1783 | 1592 | 0 | 0 | 1783 | 1886 | 1426 | 1288 | 0 | 0 | 1070 | 1357 | 758 | 89.3% | 0.0% | 105.8% | 90.3% | 0.0% | 126.9% |
| Allerton | 2933 | 2316 | 0 | 0 | 1070 | 1206 | 1426 | 1242 | 0 | 0 | 1070 | 1212 | 886 | 79.0% | 0.0% | 112.8% | 87.1% | 0.0% | 113.3% |
| Cheetham Hill | 1783 | 1776 | 0 | 0 | 2139 | 2206 | 1070 | 943 | 0 | 0 | 1426 | 2306 | 848 | 99.6% | 0.0% | 103.1% | 88.1% | 0.0% | 161.7% |
| Coronary Care | 1426 | 1445 | 0 | 0 | 0 | 92 | 1070 | 1081 | 0 | 0 | 0 | 0 | 377 | 101.3% | 0.0% | 0.0% | 101.1% | 0.0% | 0.0% |
| Cromie | 1691 | 1957 | 0 | 0 | 891 | 1425 | 1070 | 1105 | 0 | 0 | 713 | 1276 | 821 | 115.7% | 0.0% | 159.8% | 103.3% | 0.0% | 178.9% |
| Dunlop | 1426 | 1447 | 0 | 0 | 1248 | 1185 | 1070 | 1040 | 0 | 0 | 1070 | 1053 | 754 | 101.5% | 0.0% | 94.9% | 97.2% | 0.0% | 98.4% |
| Forrest | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| EAU4 | 1783 | 1968 | 0 | 0 | 1426 | 1369 | 1783 | 1482 | 0 | 0 | 1426 | 1429 | 744 | 110.4% | 0.0% | 96.0% | 83.1% | 0.0% | 100.2% |
| Ella Rowcroft | 1070 | 1121 | 0 | 0 | 1426 | 1358 | 1024 | 840 | 0 | 0 | 713 | 757 | 466 | 104.8% | 0.0% | 95.2% | 82.0% | 0.0% | 106.1% |
| Warrington | 1070 | 1291 | 0 | 0 | 713 | 973 | 713 | 823 | 0 | 0 | 713 | 948 | 494 | 120.7% | 0.0% | 136.5% | 115.4% | 0.0% | 133.0% |
| George Earle | 1783 | 1567 | 0 | 0 | 2139 | 2389 | 1070 | 1012 | 0 | 0 | 1426 | 1715 | 820 | 87.9% | 0.0% | 111.7% | 94.6% | 0.0% | 120.2% |
| ICU | 3209 | 2655 | 0 | 0 | 357 | 136 | 3209 | 2438 | 0 | 0 | 0 | 0 | 190 | 82.7% | 0.0% | 38.0% | 76.0% | 0.0% | 0.0% |
| McCullum (Escalation) | 713 | 1000 | 0 | 0 | 1070 | 986 | 713 | 759 | 0 | 0 | 1070 | 1146 | 525 | 140.3% | 0.0% | 92.2% | 106.5% | 0.0% | 107.2% |
| Louisa Cary | 2496 | 1975 | 0 | 0 | 713 | 802 | 2496 | 1530 | 0 | 0 | 713 | 828 | 442 | 79.2% | 0.0% | 112.4% | 61.3% | 0.0% | 116.1% |
| John Macpherson | 1070 | 826 | 0 | 0 | 713 | 672 | 713 | 702 | 0 | 0 | 357 | 345 | 365 | 77.2% | 0.0% | 94.3% | 98.4% | 0.0% | 96.8% |
| Midgley | 1783 | 2046 | 0 | 0 | 1783 | 1480 | 1426 | 1537 | 0 | 0 | 1426 | 1323 | 798 | 114.8% | 0.0% | 83.0% | 107.7% | 0.0% | 92.7% |
| SCBU | 1070 | 926 | 0 | 0 | 357 | 333 | 1070 | 829 | 0 | 0 | 357 | 253 | 231 | 86.5% | 0.0% | 93.5% | 77.5% | 0.0% | 71.0% |
| Simpson | 1783 | 1853 | 0 | 0 | 2139 | 2153 | 1070 | 1116 | 0 | 0 | 1426 | 2079 | 845 | 104.0% | 0.0% | 100.7% | 104.3% | 0.0% | 145.8% |
| Turner | 1426 | 1179 | 0 | 0 | 1783 | 1947 | 713 | 713 | 0 | 0 | 1426 | 1655 | 528 | 82.7% | 0.0% | 109.2% | 100.0% | 0.0% | 116.1% |
| New Forrest Ward | 1783 | 1922 | 0 | 0 | 1426 | 1772 | 1426 | 1518 | 0 | 0 | 1426 | 1730 | 891 | 107.8% | 0.0% | 124.2% | 106.4% | 0.0% | 121.3% |
| ***Total (Acute)*** | ***32074*** | ***30859*** | ***0*** | ***0*** | ***23172.5*** | ***24368.3*** | ***24552.5*** | ***21994*** | ***0*** | ***0*** | ***17825*** | ***21408.5*** | ***11783*** | 96.2% | 0.0% | 105.2% | 89.6% | 0.0% | 120.1% |
| Brixham | 868 | 1034 | 434 | 0 | 1302 | 1609.75 | 1023 | 1012 | 0 | 0 | 682 | 1032.75 | 608 | 119.1% | 0.0% | 123.6% | 98.9% | 0.0% | 151.4% |
| Dawlish | 868 | 858 | 0 | 0 | 1085 | 1109.5 | 744 | 693 | 0 | 0 | 682 | 771 | 493 | 98.8% | 0.0% | 102.3% | 93.1% | 0.0% | 113.0% |
| Newton Abbot - Teign Ward | 1953 | 1818.75 | 0 | 0 | 1953 | 2048 | 1023 | 1023 | 0 | 0 | 1023 | 1198.5 | 896 | 93.1% | 0.0% | 104.9% | 100.0% | 0.0% | 117.2% |
| Newton Abbot - Templar Ward | 1736 | 1637 | 0 | 0 | 2170 | 2058 | 1023 | 1030 | 0 | 0 | 1116 | 1122.5 | 894 | 94.3% | 0.0% | 94.8% | 100.7% | 0.0% | 100.6% |
| Totnes | 868 | 821 | 0 | 0 | 1302 | 1449.5 | 744 | 682 | 0 | 0 | 682 | 676 | 553 | 94.6% | 0.0% | 111.3% | 91.7% | 0.0% | 99.1% |
| Organisational Summary | 36584 | 35106 | 434 | 0 | 29559 | 30871 | 27684 | 24917 | 0 | 0 | 20584 | 24479 | 14336 | 96.0% | 0.0% | 104.4% | 90.0% | 0.0% | 118.9% |

# Safer Staffing – Care Hours Per Patient Day (CHPPD)

- The RN actual CHPPD has been reported as 4.19 in May but still remains below the Carter Recommendation of 4.7.
- The actual HCA CHPPD was 3.86 in May which remains above the Carter Recommendation of 2.91. This is due to the increased need for HCSW to provide 1:1 supportive observation care.
- During May the Trust was operationally challenged with 14 days in OPEL 4 and 10 days at OPEL 3
- The planned CHPPD total was reported as 6.80 with an actual of 8.05 which reflects an increase in escalation areas due to operational challenges.

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 | 0.00 | 3.80 | 0.00 | 4.30 | 31 | 19 | 0 | 1 | 100.0% | 61.3% | 0.0% | 3.2% | 7.74 | 4.74 | 0 | 2.91 |
| Allerton | 7.40 | 5.02 | 0.00 | 2.38 | 6.70 | 4.00 | 0.00 | 2.70 | 27 | 31 | 0 | 4 | 87.1% | 100.0% | 0.0% | 12.9% | 7.74 | 4.74 | 0 | 2.91 |
| Cheetham Hill | 7.39 | 3.29 | 0.00 | 4.11 | 0.00 | 3.20 | 0.00 | 5.30 | 31 | 16 | 0 | 0 | 0.0% | 25.8% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Coronary Care | 5.75 | 5.75 | 0.00 | 0.00 | 6.90 | 6.70 | 0.00 | 0.20 | 0 | 3 | 0 | 0 | 0.0% | 9.7% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Cromie | 5.75 | 3.68 | 0.00 | 2.07 | 7.00 | 3.70 | 0.00 | 3.30 | 2 | 13 | 0 | 0 | 6.5% | 41.9% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Dunlop | 6.47 | 3.35 | 0.00 | 3.11 | 6.30 | 3.30 | 0.00 | 3.00 | 15 | 13 | 0 | 19 | 48.4% | 41.9% | 0.0% | 61.3% | 7.74 | 4.74 | 0 | 2.91 |
| Forrest | 0.00 | 0.00 | 0.00 | 0.00 | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| EAU4 | 8.63 | 4.79 | 0.00 | 3.83 | 8.40 | 4.60 | 0.00 | 3.80 | 20 | 22 | 0 | 12 | 64.5% | 71.0% | 0.0% | 38.7% | 7.74 | 4.74 | 0 | 2.91 |
| Ella Rowcroft | 8.63 | 4.31 | 0.00 | 4.31 | 8.70 | 4.20 | 0.00 | 4.50 | 14 | 16 | 0 | 8 | 45.2% | 51.6% | 0.0% | 25.8% | 7.74 | 4.74 | 0 | 2.91 |
| Warrington | 6.09 | 3.38 | 0.00 | 2.71 | 8.20 | 4.30 | 0.00 | 3.90 | 0 | 3 | 0 | 1 | 0.0% | 9.7% | 0.0% | 3.2% | 7.74 | 4.74 | 0 | 2.91 |
| George Earle | 7.39 | 3.29 | 0.00 | 4.11 | 8.10 | 3.10 | 0.00 | 5.00 | 6 | 20 | 0 | 5 | 19.4% | 64.5% | 0.0% | 16.1% | 7.74 | 4.74 | 0 | 2.91 |
| ICU | 21.85 | 20.70 | 0.00 | 1.15 | 27.50 | 26.80 | 0.00 | 0.70 | 4 | 2 | 0 | 18 | 12.9% | 6.5% | 0.0% | 58.1% | 7.74 | 4.74 | 0 | 2.91 |
| McCullum (Escalation) | 6.76 | 2.71 | 0.00 | 4.06 | 7.40 | 3.40 | 0.00 | 4.10 | 4 | 1 | 0 | 9 | 12.9% | 3.2% | 0.0% | 29.0% | 7.74 | 4.74 | 0 | 2.91 |
| Louisa Cary | 10.89 | 8.47 | 0.00 | 2.42 | 11.60 | 7.90 | 0.00 | 3.70 | 11 | 17 | 0 | 1 | 0.0% | 54.8% | 0.0% | 3.2% | 7.74 | 4.74 | 0 | 2.91 |
| John Macpherson | 5.11 | 3.19 | 0.00 | 1.92 | 7.00 | 4.20 | 0.00 | 2.80 | 5 | 5 | 0 | 4 | 16.1% | 16.1% | 0.0% | 12.9% | 7.74 | 4.74 | 0 | 2.91 |
| Midgley | 7.96 | 3.98 | 0.00 | 3.98 | 8.00 | 4.50 | 0.00 | 3.50 | 16 | 2 | 0 | 26 | 51.6% | 6.5% | 0.0% | 83.9% | 7.74 | 4.74 | 0 | 2.91 |
| SCBU | 9.20 | 6.90 | 0.00 | 2.30 | 10.10 | 7.60 | 0.00 | 2.50 | 10 | 9 | 0 | 13 | 32.3% | 29.0% | 0.0% | 41.9% | 7.74 | 4.74 | 0 | 2.91 |
| Simpson | 7.39 | 3.29 | 0.00 | 4.11 | 8.50 | 3.50 | 0.00 | 5.00 | 0 | 8 | 0 | 0 | 0.0% | 25.8% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Turner | 9.58 | 3.83 | 0.00 | 5.75 | 10.40 | 3.60 | 0.00 | 6.80 | 6 | 21 | 0 | 2 | 19.4% | 67.7% | 0.0% | 6.5% | 7.74 | 4.74 | 0 | 2.91 |
| New Forrest Ward | 6.74 | 3.57 | 0.00 | 3.17 | 7.80 | 3.90 | 0.00 | 3.90 | 1 | 4 | 0 | 0 | 3.2% | 12.9% | 0.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Brixham | 6.95 | 3.05 | 0.70 | 3.20 | 7.70 | 3.40 | 0.00 | 4.30 | 1 | 6 | 31 | 0 | 3.2% | 19.4% | 100.0% | 0.0% | 7.74 | 4.74 | 0 | 2.91 |
| Dawlish | 6.81 | 3.25 | 0.00 | 3.56 | 7.00 | 3.10 | 0.00 | 3.80 | 13 | 19 | 0 | 16 | 41.9% | 61.3% | 0.0% | 51.6% | 7.74 | 4.74 | 0 | 2.91 |
| Newton Abbot - Teign Ward | 6.40 | 3.20 | 0.00 | 3.20 | 6.80 | 3.20 | 0.00 | 3.60 | 3 | 17 | 0 | 2 | 9.7% | 54.8% | 0.0% | 6.5% | 7.74 | 4.74 | 0 | 2.91 |
| Newton Abbot - Templar Ward | 6.50 | 2.97 | 0.00 | 3.53 | 6.50 | 3.00 | 0.00 | 3.60 | 14 | 12 | 0 | 15 | 45.2% | 38.7% | 0.0% | 48.4% | 7.74 | 4.74 | 0 | 2.91 |
| Totnes | 6.44 | 2.89 | 0.00 | 3.56 | 6.60 | 2.70 | 0.00 | 3.80 | 12 | 22 | 0 | 6 | 38.7% | 71.0% | 0.0% | 19.4% | 7.74 | 4.74 | 0 | 2.91 |

# Community and Social Care Indicators

| Key | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ↑ = Performance improved from previous month | | | ↓ = Performance deteriorated from previous month | | | ⟷ = No change | | | |
| (red) | Not achieved | (amber) | Under-achieved | (green) | Achieved | (grey) | No target set | (blank) | Data not available |

| Indicator | Status | Trend |
|---|---|---|
| Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears) | Under-achieved | ⟷ |
| DOLS - Deprivation of Liberty Standard | No target set | |
| Intermediate Care - No. urgent referrals | Achieved | |
| Community Hospital - Admissions (non-stroke) | No target set | |
| Community Hospital average Length of Stay (days) | No target set | |
| Urgent Community Response 2 hours | Achieved | ↓ |
| Urgent Community Response 2 to 48 hours | No target set | |
| Proportion of clients receiving self-directed support (ASCOF) - metric removed from national framework | | |
| Proportion of carers receiving self-directed support (ASCOF) - metric removed from national framework | | |
| Percentage of Adults with learning disabilities in employment (ASCOF) - metric removed from national framework | | |
| Percentage of adults with learning disabilities in settled accommodation (ASCOF) - metric removed from national framework | | |
| Permanent admissions (18-64) to care homes per 100k population (ASCOF) | Not achieved | ↑ |
| Permanent admissions (65+) to care homes per 100k population (ASCOF) | Not achieved | ↑ |
| Proportion of clients receiving direct payments (ASCOF) | Not achieved | ⟷ |
| % reablement episodes not followed by long term SC support | Achieved | ↑ |

Narrative and data to support the community and social care indicators is provided in the Chief Operating Officer Report.

# Operational Performance Indicators

| Key | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ↑ = Performance improved from previous month | | ↓ = performance deteriorated from previous month | | ↔ = no change | | | | | | | |
| (red) | Not achieved | (amber) | Under-achieved | (green) | Achieved | (grey) | No target set | (blank) | Data not available | (beige) | NHSI Indicator |

| Indicator | Status | Trend |
|---|---|---|
| A&E - patients seen within 4 hours (NHSI) | Not achieved | ↓ |
| Referral to treatment - % Incomplete pathways <18 wks (NHSI) | Not achieved | ↑ |
| Cancer - 62-day wait for first treatment - 2ww referral | Not achieved | ↓ |
| Diagnostic tests longer than the 6-week standard (NHSI) | Not achieved | ↑ |
| Dementia Find (NHSI) | Achieved | ↑ |
| Cancer - Two week wait from referral to date 1st seen | Not achieved | ↑ |
| Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients | Not achieved | ↓ |
| Cancer – 28-day faster diagnosis standard | Achieved | ↑ |
| Cancer - 31-day wait from decision to treat to first treatment | Not achieved | ↑ |
| Cancer - 31-day wait for second or subsequent treatment - Drug | Achieved | ↑ |
| Cancer - 31-day wait for second or subsequent treatment - Radiotherapy | Achieved | ↓ |
| Cancer - 31-day wait for second or subsequent treatment – Surgery | Not achieved | ↓ |
| Cancer – 62-day wait for first treatment – screening | Achieved | ↔ |
| Cancer - Patient waiting longer than 104 days from 2 week wait | Achieved | ↑ |
| RTT 52-week wait incomplete pathway | Not achieved | ↑ |
| RTT 65-week wait incomplete pathway | Not achieved | ↑ |
| RTT 78-week wait incomplete pathway | Not achieved | ↓ |
| RTT 104-week wait incomplete pathway (Tier 1) | Achieved | ↔ |
| On the day cancellations for elective operations | Not achieved | ↓ |

| Indicator | Status | Trend |
|---|---|---|
| Cancelled patients not treated within 28 days of cancellation | Not achieved | ↓ |
| Virtual Outpatient (Non-face-to-face) appointments | Not achieved | ↓ |
| Bed Occupancy (Acute) | Not achieved | ↓ |
| No Criteria to Reside – percentage - (acute) | Not achieved | ↑ |
| Percentage of patient discharges pre-noon | Not achieved | ↔ |
| Percentage of patient discharges pre-5pm | Not achieved | ↓ |
| Number of patients >7 days LoS (daily average) | Not achieved | ↓ |
| Number of extended stay patients >21 days (daily average) | Not achieved | ↑ |
| Ambulance handover delays > 30 minutes | Not achieved | ↓ |
| Ambulance handover delays > 60 minutes | Not achieved | ↓ |
| A&E - patients with >12-hour visit time pathway | No target set | ↓ |
| Time to Initial Assessment within 15 mins – Emergency Department | No target set | ↓ |
| Clinically Ready to Proceed delay over 1 hour - Emergency Department | No target set | ↑ |
| Non-admitted minutes mean time in Emergency Department | No target set | ↓ |
| Admitted minutes mean time in Emergency Department | No target set | ↓ |
| Care Planning Summaries % completed within 24 hours of discharge – Weekend | Not achieved | ↓ |
| Care Planning Summaries % completed within 24 hours of discharge – Weekday | Not achieved | ↑ |
| Clinic letters timeliness - % specialties within 4 working days | Not achieved | ↓ |

# Financial Performance
# Month 02 (May-23)
# FY 23/24

# Contents Page

*Working with you, for you*

# Executive Summary

| Description | YTD Plan £M | YTD Actual £M | YTD Var £M | YTD Var % | R.A.G |
|---|---|---|---|---|---|
| Operating Income | 104.85 | 106.50 | 1.66 | 2% | |
| Operating Expenditure and Financing Costs | (114.61) | (115.96) | (1.34) | 1% | |
| **Surplus / (Deficit)** | (9.77) | (9.46) | 0.31 | (3%) | |
| Add back: Donated Assets | (0.16) | (0.17) | (0.01) | 3% | |
| **Adjusted Surplus / (Deficit)** | (9.93) | (9.62) | 0.31 | (3%) | |
| Capital (CDEL) | 3.62 | 2.09 | (1.53) | (42%) | |
| Cash & Cash Equivalents | 15.80 | 27.80 | 12.01 | 76% | |

**Variance Key:**

Positive Values = favourable variance
Negative Values = adverse variance

- Favourable variance is greater than £50k
- Adverse or favourable variance is less than £50k
- Adverse variance is greater than £50k

As of May 2023, the financial performance indicated a minor departure from the anticipated plan, maintaining overall stability. Our operating income reached **£106.5m**, slightly higher by **£1.66m** compared to the projected **£104.85m** plan, of which an additional 2.0% pay award had been accounted for.

Similarly, the operating expenditure was greater than our budgeted cost, with the actual expenditure standing at **£115.96m** against the expected **£114.61m**.

This resulted in an adverse variance of **(£1.34m**), which included additional pay award uplift plus savings delivery ahead of plan, bearing in mind the CIP (Costed Improvement Plans) target phasing is relatively low in the first quarter. It is also important to note that the operating expenditure includes an unplanned cost pressure of **£0.16m** due to the Junior Doctors Industrial Action. Anticipating that this cost will escalate with further industrial action in June, mitigation strategies will be necessary.
The period concluded with a deficit of **£9.62m**, marginally better than the forecasted deficit of **£9.93m**, resulting in a moderate positive variance of **£0.31m**.

# I&E – Year to Date Position

| System | YTD Plan £M | YTD Actual £M | YTD Variance £M | R.A.G | Commentary |
|---|---|---|---|---|---|
| Children and Family Health Devon (CHFD) | 0.10 | 0.39 | 0.30 | | Additional Alliance income to offset expenditure |
| Families, Community and Home | (32.51) | (33.40) | (0.89) | | Additional Safer Staffing and ASC costs |
| Planned Care, Long Term Conditions | (26.47) | (26.38) | 0.09 | | Mainly for vacancies reported across the System offset by additional Outsourcing |
| Urgent & Emergency Care and Operations | (8.42) | (8.78) | (0.35) | | Additional Nursing escalation costs and Senior Medical pay |
| Pharmacy Manufacturing Unit | 0.06 | 0.18 | 0.12 | | Additional income generated |
| Shared Corporate Services | 57.31 | 58.36 | 1.04 | | Technical finance costs (lower depreciation / increase in interest income) is aiding the favourable YTD variance |
| Total | (9.93) | (9.62) | 0.31 | | |

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# I&E - In Month Position

| | M02 | | |
|---|---|---|---|
| | Plan £M | Actual £M | Variance £M |
| Patient Income - Block | 42.80 | 44.31 | 1.50 |
| Patient Income - Variable | 3.88 | 4.17 | 0.30 |
| ASC Income - Council | 1.21 | 1.42 | 0.21 |
| Other ASC Income - Contribution | 0.36 | 0.19 | (0.17) |
| Torbay Pharmaceutical Sales | 1.71 | 1.95 | 0.24 |
| Other Income | 2.48 | 2.56 | 0.08 |
| **Total Income (A)** | **52.44** | **54.60** | **2.16** |
| Pay - Substantive | (27.09) | (28.56) | (1.47) |
| Pay - Agency | (1.01) | (1.52) | (0.51) |
| Non-Pay - Other | (13.93) | (13.73) | 0.20 |
| Non- Pay - ASC/CHC | (11.82) | (12.31) | (0.48) |
| Financing & Other Costs | (3.71) | (3.34) | 0.38 |
| **Total Expenses (B)** | **(57.56)** | **(59.45)** | **(1.89)** |
| Sub-Total Surplus/(Deficit) (A+B) | (5.12) | (4.86) | 0.28 |
| Adjustments - Donated Items / Impairment / Gain on Asset disposal | (0.09) | (0.07) | 0.02 |
| Adjusted Surplus / (Deficit) | (5.22) | (4.92) | 0.30 |

**Overview** - the planned deficit for May-23 was **(£5.12m)**. The actual net expenditure reported was **(£4.86m)**. Therefore, showing a favourable variance to the plan of **£0.28m** in month.

**Income** - Patient and Other Income of **£54.60m** reported in May-23 variance was **£2.16m** higher than plan, which include the anticipated additional 2% funding for pay award.

**Pay** – Total Pay expenditure (Substantive & Agency) of **£30.08m**, was **£1.98m** above plan which includes the additional pay award uplift at 2% contributing to this adverse variance. The plan will be adjusted in M03 following the pay award agreement.
Agency continues as at M02 to show an adverse variance against plan of **(£0.51m)** with the highest level of spend occurring in the following areas

- Nursing and Midwifery – **0.61M**
- Medical and Dental – **£0.4M**
- Non-Clinical – **0.3M**

Non-pay - Total Non-Pay expenditure of **£29.38m** reported in May-23 was **£0.09m** below plan.

# I&E – In Month Position System overview

| System | Plan £M | Actual £M | Variance £M | R.A.G | Commentary |
|---|---|---|---|---|---|
| Children and Family Health Devon (CHFD) | 0.05 | 0.26 | 0.21 | | Additional Alliance income to offset expenditure |
| Families, Community and Home | (16.42) | (16.90) | (0.48) | | Additional Safer Staffing and ASC costs |
| Planned Care, Long Term Conditions | (13.23) | (13.15) | 0.08 | | Mainly for vacancies reported across the System offset by additional Outsourcing |
| Urgent & Emergency Care and Operations | (4.21) | (4.22) | (0.01) | | Additional Nursing escalation costs and Senior Medical pay |
| Pharmacy Manufacturing Unit | 0.03 | 0.13 | 0.10 | | Additional income generated |
| Shared Corporate Services | 28.56 | 28.96 | 0.40 | | Technical Finance Costs ( Lower depreciation / increase in interest income) is aiding the favourable YTD variance |
| **Total** | **(5.22)** | **(4.92)** | **0.30** | | |

# Drivers of System Position (1/3)

| System | ISU | Financial Commentary / Key Drivers |
|---|---|---|
| CFHD | CFHD | Budget has been set on approved model 2023/24. At M02, the Alliance generated a surplus and after applying a risk share calculation, TSD is benefiting from **£0.4m** surplus to the I&E. The actual expenditure run rate remains constant. With the launch and implementation of the new pathway model, recruitment is commencing to fill current live vacancies - these vacancies are the main contributor to the current underspend. SystemOne EPR revenue has been budgeted for in this year and has been included within forecast from July 2023 onwards. |
| Families, Community and Home | Torquay | An overspend of **(£0.08m)** reported to date against a budget of **(£7.62m)**, included: **(£0.39m)** of under achieved CIP, offset by Pay and Non-Pay under spends of **£0.15m** and additional income of **£0.16m**. |
| Families, Community and Home | Moor to Sea | An overspend of **(£0.17m)** reported to date against a budget of **(£4.2m)**, included: **(£0.32m)** of under achieved CIP, offset by Pay and Non-Pay under spends of **£0.15m.** |
| Families, Community and Home | Independent Sector | An overspend of **(£0.64m)** reported to date against a budget of **(£20.7m)**, included: **(£0.47m)** of under achieved CIP, **(£0.37m)** ASC Non-Pay expenditure, offset by additional income of **£0.2m.** |
| Pharmacy Manufacturing Unit | Pharmacy Manufacturing Unit | TP performance is reported privately. |

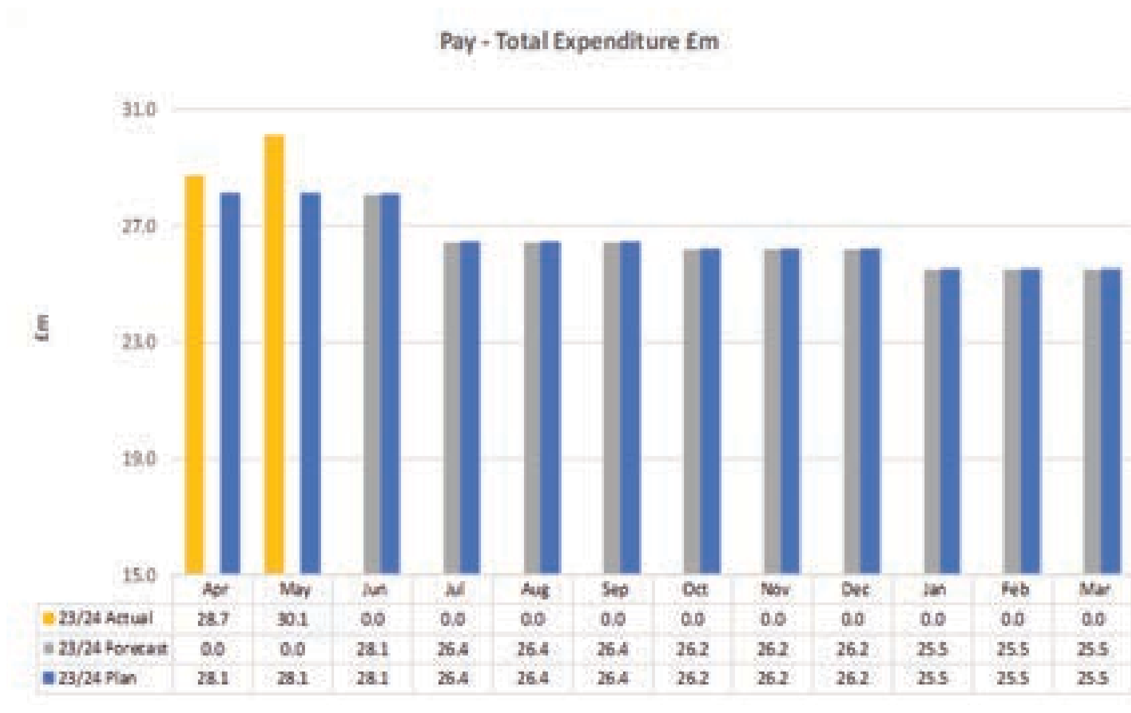
# Drivers of System Position (2/3)

| System | ISU | Financial Commentary / Key Drivers |
|---|---|---|
| Planned Care, Long Term Conditions | Paignton and Brixham | An underspend of **£0.1m** reported to date against a budget of **(£12.3m)** was mainly for vacancy slippage of **£0.6m**, offset by under achieved CIP of (**£0.5m).** |
| Planned Care, Long Term Conditions | Coastal | The ISU reported a break-even position to date against a budget of **(£14.2m)**. However the break-even position was the net of:<br>**- (£0.85m)** under achieved CIP to date, offset by;<br>- Pay underspends of **£0.37m** for vacancies in place, Non-Pay clinical consumable and equipment underspend of **£0.2m** and additional income of **£0.17m** |
| Urgent & Emergency Care and Operations | Newton Abbot | An overspend of (**£0.4m)** reported to date against a budget of **(£7.06m)** was mainly due to under achieved CIP to date. |
| Urgent & Emergency Care and Operations | Trust Wide Support Services | An underspend of **£0.06m** to date against a budget of **(£1.37m)** was mainly underspend against security non-pay expenditure. |

# Drivers of System Position (3/3)

| System | ISU | Financial Commentary / Key Drivers |
|---|---|---|
| Shared Corporate Services | Workplace Team | An overspend of **(£0.2m)** reported to date against a budget of **(£4.37m)** was due to under achieved CIP to date of **(£0.3m)**. The under spends of **£0.1m** were mainly against pay for various vacancies in place. |
| Shared Corporate Services | Executive Directors | An underspend of **£0.2m** reported to date against a budget of **(£8.0m)** was the net of; additional Education and other income of **£0.3m,** Pay underspend of **£0.2m** for various vacancies across the ISU, Non-Pay underspend of **£0.1m**, offset by under achieved CIP to date of **(£0.4m)**. |
| Shared Corporate Services | Financing Costs | Excluding items outside the NHSE control total, costs are **£0.68m** favourable to plan. This is principally due to fixed assets being brought into service later than planned, resulting in a depreciation charge **£0.38m** favourable to plan. In addition, higher interest than planned has been received **£0.28m**. |
| Shared Corporate Services | Other | Other Shared Corporate Services under spend of **£0.4m** was mainly against Reserves & Other Income for under spends against budgeted high cost drugs growth. |

# Pay Expenditure – Run Rate




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23/24 Actual | 28.7 | 30.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 23/24 Forecast | 0.0 | 0.0 | 28.1 | 26.4 | 26.4 | 26.4 | 26.2 | 26.2 | 26.2 | 25.5 | 25.5 | 25.5 |
| 23/24 Plan | 28.1 | 28.1 | 28.1 | 26.4 | 26.4 | 26.4 | 26.2 | 26.2 | 26.2 | 25.5 | 25.5 | 25.5 |

The graph compares the pay expenditure for May-23, set against previous years. It includes a projection for the current FY23/24, which reflects our financial plan.

In line with national directives, we anticipate that the pay award for FY23/24 will be implemented in Jun-23.

Pay expenditure for May-23 amounted to **£30.1m**, exceeding the plan by **£1.98m**.
The variance is primary due to the pay award with secondary cause of the movement above plan items relating from additional agency and bank staff

# Pay Expenditure – Agency and Bank

**Agency Run Rates £m**

| £m | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23/24 Plan | 1.0 | 1.0 | 1.0 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 |
| 23/24 Actual | 1.4 | 1.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 23/24 Forecast | 0.0 | 0.0 | 1.0 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 |

**Bank Run Rates £m**

| £m | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23/24 Plan | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 |
| 23/24 Actual | 1.4 | 1.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 23/24 Forecast | 0.0 | 0.0 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 |

| ISU | Agency YTD £'000 |
|---|---|
| Newton Abbot | 735 |
| Coastal | 629 |
| Moor to Sea | 416 |
| Paignton & Brixham | 389 |
| Executive Directors | 192 |

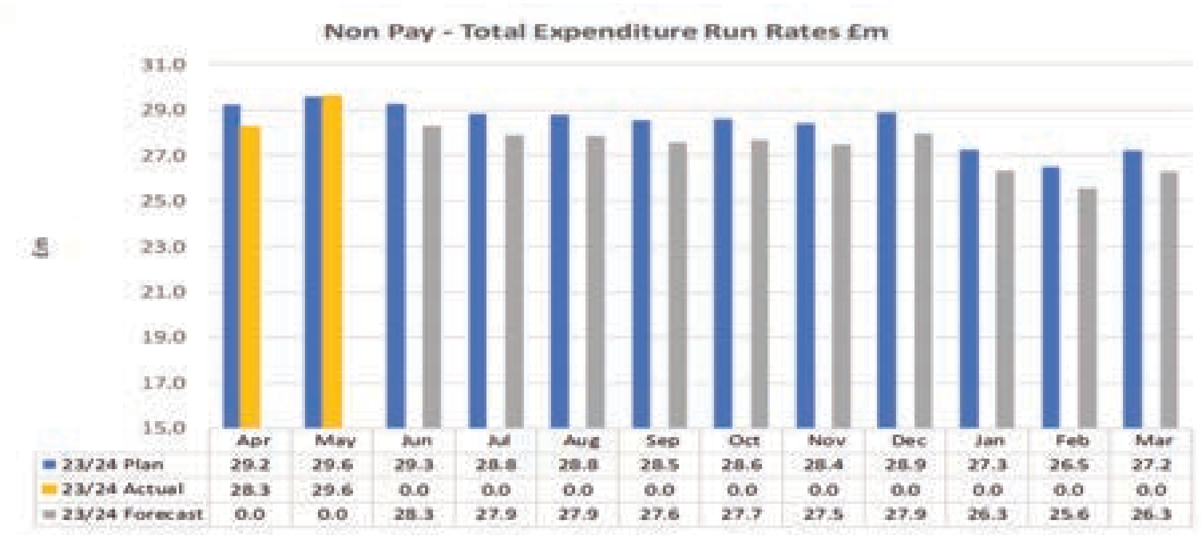
Top 5 ISU Agency YTD Spend

| ISU | Bank YTD £'000 |
|---|---|
| Coastal | 579 |
| Newton Abbot | 533 |
| Moor to Sea | 303 |
| Paignton & Brixham | 354 |
| Torquay | 227 |

Top 5 ISU Bank YTD Spend

Agency and bank staff have been pivotal in covering vacancies, managing sickness-related absences, and navigating the recent Junior Doctors' industrial action. As shown from the charts, there was a marked rise in the deployment of agency and bank staff during April-23 and May-23. This surge was triggered by a combination of increased vacancies, sickness, industrial action, and patient activity. Moving forward, we need to proactively implement measures to reduce the reliance on agency and bank staff, to remain within our designated plan and agency cap set by NHSE/I, a ceiling of **£9.7m**.

# Non-Pay Expenditure – Run Rate




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23/24 Plan | 29.2 | 29.6 | 29.3 | 28.8 | 28.8 | 28.5 | 28.6 | 28.4 | 28.9 | 27.3 | 26.5 | 27.2 |
| 23/24 Actual | 28.3 | 29.6 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 23/24 Forecast | 0.0 | 0.0 | 28.3 | 27.9 | 27.9 | 27.6 | 27.7 | 27.5 | 27.9 | 26.3 | 25.6 | 26.3 |

In May 2023 the Non-Pay expenditure was **£0.09m** less than plan.

Non-Pay expenditure trends in March 2023 increased due to the revaluation of Trust assets. The revaluation of the Trust assets will be completed again in March 2024, for which the impact is not known at present.

# Income – Run Rate

Income was reported **£1.66m** higher than plan in May 2023, mainly for additional pay award funding.

# Income from Patient Activities and Other Income

Income reported in May 2023 was **£1.66m** higher than plan, mainly against Clinical Contract Income, which includes the anticipated additional pay award funding. Income trends in previous years were in line with patient activities and other ad-hoc income generation.

# Activity Performance (1/2)

| Setting | M01 19/20 Activity Baseline | M01 23/24 Activity Plan | M01 23/24 Actual Activity | M01 23/24 Activity vs 19/20 Baseline. | M01 23/24 Actual Activity vs 23/24 Activity Plan | M02 19/20 Activity Baseline | M02 23/24 Activity Plan | M02 23/24 Actual Activity | M02 23/24 Activity vs 19/20 Baseline. | M02 23/24 Activity vs 23/24 Activity Plan |
|---|---|---|---|---|---|---|---|---|---|---|
| DC | 2,423 | 2,086 | 1,973 | 81.4% | 94.6% | 2,666 | 2,633 | 2,424 | 90.9% | 92.1% |
| EL | 264 | 247 | 215 | 81.4% | 87.2% | 310 | 273 | 284 | 91.6% | 104.2% |
| OPAFA | 7,005 | 7,495 | 6,339 | 90.5% | 84.6% | 7,932 | 8,097 | 7,660 | 96.6% | 94.6% |
| OPROCFA | 1,465 | 1,799 | 1,525 | 104.1% | 84.8% | 1,667 | 1,856 | 2,047 | 122.8% | 110.3% |
| OPROCFU | 3,680 | 3,676 | 3,976 | 108.0% | 108.2% | 4,302 | 4,408 | 4,313 | 100.3% | 97.9% |
| **Grand Total** | **14,837** | **15,302** | **14,028** | **94.5%** | **91.7%** | **16,877** | **17,266** | **16,728** | **99.1%** | **96.9%** |

Only Outpatient procedures meet the 2019/20 baseline, however the movement from M1 to M2 shows an improvement in all areas against both the 2019/20 baseline and the FY23/24 plan. This was mainly due to M1 strike action and the delay in confirmation of ESRF (Elective Service Recovery Fund) schemes. Allowing for strike action and bank holidays the overall actual vs 19/20 % progression is promising.

# Activity Performance (2/2)

ESRF activity continues to support our elective recovery with additional outpatient activity being scheduled for:

- Urology,
- Colorectal,
- UPGI (Medac)
- ENT (Medinet)
- Neurology (Medinet & Your Medical Services)
- and for IP/DC Ophthalmology - cataracts (18wks & Optimax)
- Gastroenterology – Endoscopy (inHealth & Elective Services)
- Urology (18wks)

This is having a positive effect on our long wait position.

Further work is being done to provide additional capacity for Trauma and Orthopaedics, Ophthalmology, and Clinical Neuro-Phys.

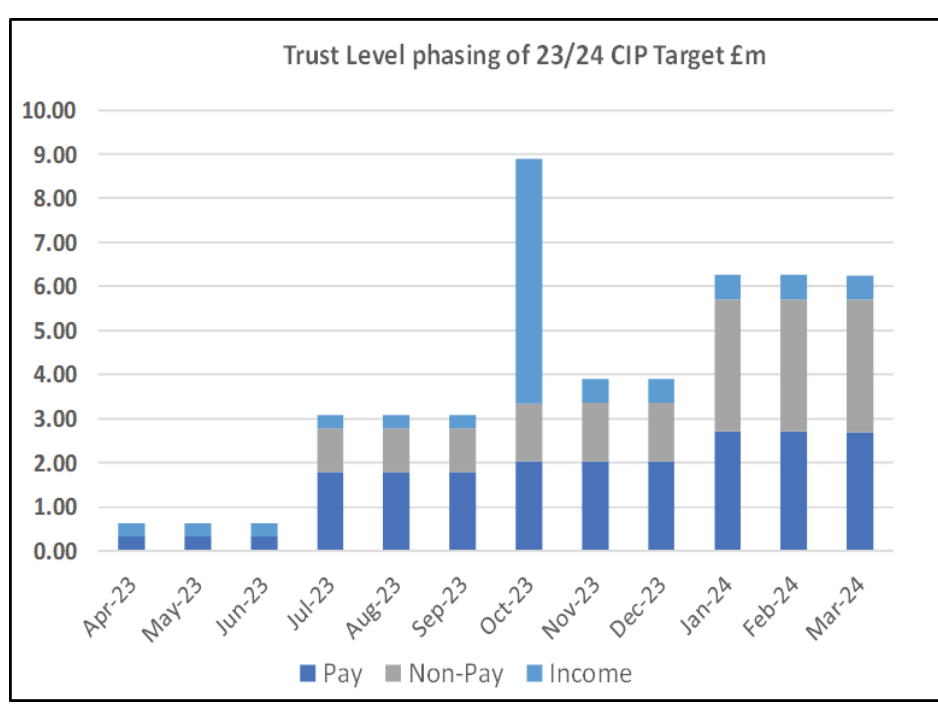
The current national expectation for 2023/24 is to eliminate waits greater than 104 weeks, 78 weeks and 65 weeks by the 31 March 2024 (also part of the SOF 4 exit criteria); to date we are the only provider in the Devon ICB to have eliminated their 104-week waits (TSDFT achieved zero in March 2023).

Against our 78-week trajectory we are ahead of plan achieving 166 in May against a plan of 170 and against our 65 week trajectory we are again ahead of plan achieving 1,163 against a plan of 1,362.

Our total cohort of 65-week breaches (the total number that could potentially become a 65-week breach at the 31 March 2023) has reduced from 24,018 at the 1 April 2023 to 14,905 a reduction of 9,113 in 11 weeks – this positive reduction has resulted in the Trust being required to improve its March 2024 forecast and to totally eliminate 65-week breaches.

During the months of April and May teams have had to contend with a high number of bank holidays and industrial action, but through their proactive management, disruption was kept to a minimum with minimal cancellation of patients awaiting cancer treatment, or to our long wait patients.

# CIP Target 2023/24




The Trust is required to deliver a savings target of **£46.6M**, which includes **£10.5M** to be delivered through collaborative schemes within the Devon system. CIP requirement has been apportioned between ISU's on the basis of:

- Specific targeted areas identified at time of the submission of the Trust's plan in March
- Underdelivered recurrent CIP from FY22/23
- A sharing of the residual balance as a percentage of overall budget.

This process has identified our CIP target split as following:

- Pay - 44% / **£20.5M**
- Non Pay - 34% / **£16.0M**
- Income - 22% / **£10.1M**

The calculation has been carried out at a specialty level (as held within the finance system structure) to enable adjustments to be made, should the structure of ISU's change through the year.

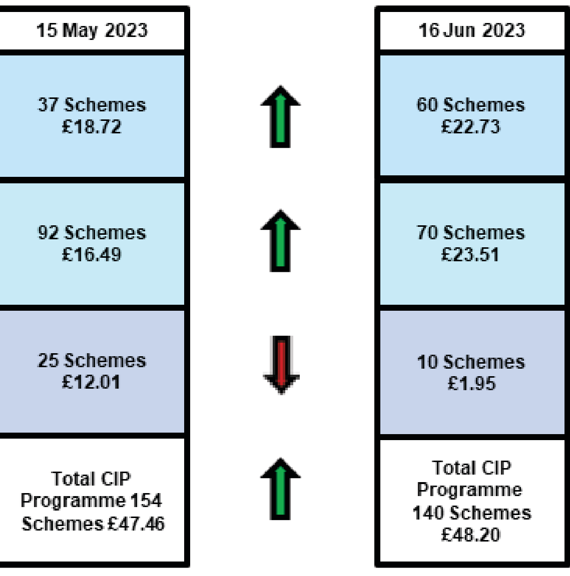
# 2023/24 Pipeline

For the financial year FY23/24, the total recurrent CIP delivery requirement is **£46.6m**. As of 16th June, the FY23/24 CIP programme includes 140 schemes, of which 60 schemes (43%) totalling £22.7m are assessed as Green and have been confirmed in the Plan.
Divisions and workstreams are working through 80 new ideas, at a high-level value of **£25.5m**.

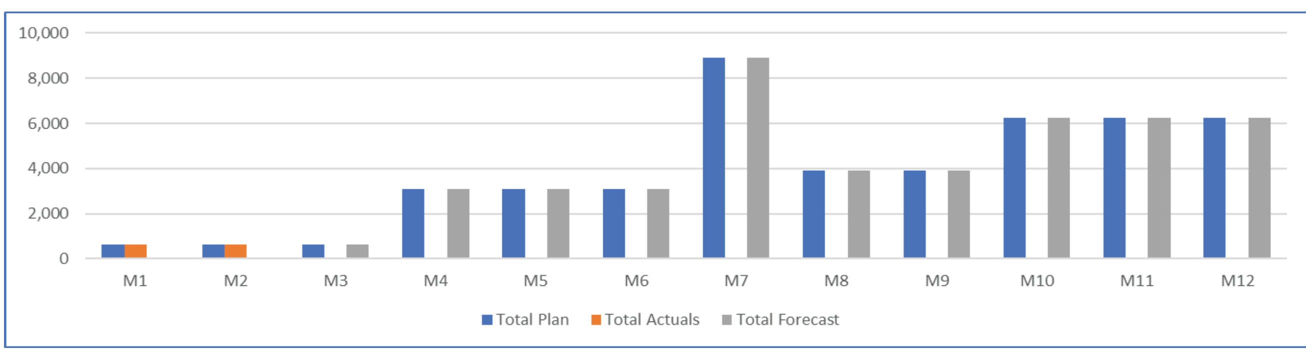
The Strategic ICB Collaborative schemes totalling **£10.5m** have been assessed as Amber by the PMO on the basis that although there are signed off PIDs in place, there is not a clear delivery plan for these schemes available, and therefore a substantial focus will be required to accept into the plan.

Scoping work continues to be developed whilst maintaining a balance with ensuring the delivery of existing schemes. Considerable focus must be placed on Amber and Red schemes to reach the in-year target.
It is highly likely that with risk adjustment of the CIP plan of **£46.6m**, that the full value of schemes required to be implemented for FY23/24 will need to be significantly higher (a minimum of **£51m**) to deliver in year savings of **£46.6m**.

Currently, if all the schemes included in the pipeline were to be developed and pass through the governance process, the total programme would be in the region of **£48.2m** (non-risk-adjusted value).



# Executive Summary 2023/24 CIP Plan/Actuals/FC




| | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | 23/24 | Non-Rec | Rec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Income | 300 | 300 | 298 | 300 | 300 | 298 | 5,550 | 550 | 548 | 550 | 550 | 548 | **10,092** | 8,872 | 1,220 |
| | Non-Pay | 0 | 0 | 0 | 988 | 988 | 991 | 1,327 | 1,328 | 1,330 | 2,996 | 2,996 | 3,004 | **15,948** | 1,751 | 14,197 |
| | Pay | 325 | 325 | 325 | 1,795 | 1,794 | 1,793 | 2,021 | 2,022 | 2,020 | 2,710 | 2,710 | 2,698 | **20,538** | 5,150 | 15,388 |
| | **Total Plan** | **625** | **625** | **623** | **3,083** | **3,082** | **3,082** | **8,898** | **3,900** | **3,898** | **6,256** | **6,256** | **6,250** | **46,578** | **15,773** | **30,805** |
| Actuals | Income | 208 | 208 | | | | | | | | | | | **416** | 0 | 416 |
| | Non-Pay | 163 | 163 | | | | | | | | | | | **326** | 53 | 272 |
| | Pay | 264 | 264 | | | | | | | | | | | **528** | 151 | 375 |
| | **Total Actuals** | **635** | **635** | | | | | | | | | | | **1,270** | **204** | **1,063** |
| Forecast | Income | *129* | *129* | *128* | *634* | *634* | *634* | *1,830* | *802* | *802* | *1,287* | *1,287* | *1,285* | *9,579* | *3,562* | *6,017* |
| | Non-Pay | *251* | *251* | *250* | *1,238* | *1,238* | *1,238* | *3,573* | *1,566* | *1,565* | *2,512* | *2,512* | *2,510* | *18,704* | *4,431* | *14,273* |
| | Pay | *245* | *245* | *245* | *1,211* | *1,211* | *1,211* | *3,495* | *1,532* | *1,531* | *2,457* | *2,457* | *2,455* | *18,295* | *4,970* | *13,325* |
| | **Total Forecast** | ***625*** | ***625*** | ***623*** | ***3,083*** | ***3,082*** | ***3,082*** | ***8,898*** | ***3,900*** | ***3,898*** | ***6,256*** | ***6,256*** | ***6,250*** | ***46,578*** | ***12,963*** | ***33,615*** |

The Trust delivered **£1.27m** YTD at Month 2 compared to a plan target of **£1.25m** (102%), with a recurrent to non-recurrent delivery split of 81% /19%.

# Cash Position / Better Payment Practice

| | YTD Plan £M | YTD Actual £M | YTD Variance £M |
|---|---|---|---|
| **Opening cash balance** | **14.96** | **34.73** | **19.77** |
| Capital Expenditure (accruals basis) | (3.67) | (2.07) | 1.59 |
| Capital loan/PDC drawndown | 1.06 | 0.00 | (1.06) |
| Capital loan repayment principal | (0.55) | (0.72) | (0.17) |
| Proceeds on disposal of assets | 0.00 | 0.00 | 0.00 |
| Movement in capital creditor | 0.00 | (11.98) | (11.98) |
| Other capital-related elements | (0.43) | (0.45) | (0.03) |
| **Sub-total - capital-related elements** | **(3.59)** | **(15.22)** | **(11.63)** |
| | | | |
| Cash Generated From Operations | (4.48) | (4.82) | (0.34) |
| Revenue PDC drawndown | 9.93 | 4.77 | (5.16) |
| Working Capital movements - debtors | (0.38) | (3.02) | (2.64) |
| Working Capital movements - creditors | (0.01) | 11.74 | 11.75 |
| Net Interest | (0.42) | (0.16) | 0.26 |
| PDC Dividend paid | 0.00 | 0.00 | 0.00 |
| Other movements | (0.22) | (0.22) | (0.00) |
| **Sub-total - other elements** | **4.43** | **8.29** | **3.87** |
| Closing cash balance | 15.80 | 27.80 | 12.01 |

| Better Payment Practice Code | Paid | Paid within Target | Paid within Target % |
|---|---|---|---|
| Non-NHS - number of bills | 20,965 | 18,604 | 88.7% |
| Non-NHS - value of bills (£k) | 51,254 | 43,151 | 84.2% |
| NHS - number of bills | 231 | 166 | 71.9% |
| NHS - value of bills (£k) | 3,935 | 3,644 | 92.6% |
| Total - number of bills | 21,196 | 18,770 | 88.6% |
| Total - value of bills (£k) | 55,189 | 46,795 | 84.8% |

- Access to capital and revenue PDC support remains absolutely critical to the Trust's cashflow. FY23/24 planned PDC funding is **£70.8m** (FY22/23 actual: **£45.3m**).
- Unlike in previous years, the plan has had to be submitted to NHSE prior to the end of the previous financial year. Planned opening balances will not therefore match actual opening balances.
- The opening cash balance was **£19.8m** higher than planned. This is principally due to the March 2023 capital creditor having been higher than assumed.
- Capital-related cashflow is **(£12m)** adverse, largely due to further pay down of the capital creditor. The plan assumed that this would have happened at the end of the previous year.
- Creditor movements is **£11.7m** favourable. This is primarily due to the timing of the weekly payments run, with unusually high payments of **£15.0m** having been made on the 1st June 2023. NHSE (formerly HEE) funding of **£1.4m** has also been received in advance.

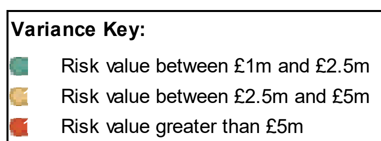
# Balance Sheet

| | YTD Plan £M | YTD Actual £M | YTD Variance £M |
|---|---|---|---|
| Intangible Assets | 11.88 | 16.91 | 5.04 |
| Property, Plant & Equipment | 248.29 | 232.94 | (15.35) |
| On-Balance Sheet PFI | 17.23 | 20.22 | 2.99 |
| Right of Use assets | 19.74 | 21.13 | 1.39 |
| Other | 1.84 | 1.55 | (0.30) |
| **Non-Current Assets Total** | **298.99** | **292.75** | **(6.23)** |
| Cash & Cash Equivalents | 15.80 | 27.80 | 12.01 |
| Other Current Assets | 41.04 | 57.51 | 16.46 |
| **Current Assets Total** | **56.84** | **85.31** | **28.47** |
| **Total Assets** | **355.82** | **378.06** | **22.23** |
| Loan - DHSC ITFF | (2.92) | (2.92) | (0.00) |
| PFI and Leases | (4.65) | (4.78) | (0.13) |
| Trade and Other Payables | (54.19) | (82.20) | (28.01) |
| Other Current Liabilities | (5.10) | (9.48) | (4.38) |
| **Current Liabilities Total** | **(66.85)** | **(99.38)** | **(32.52)** |
| **Net Current Assets/(liabilities)** | **(10.01)** | **(14.07)** | **(4.06)** |
| Loan - DHSC ITFF | (21.74) | (21.57) | 0.17 |
| PFI and Leases | (30.79) | (31.66) | (0.87) |
| Other Non-Current Liabilities | (4.62) | (4.58) | 0.03 |
| **Non-Current Liabilities Total** | **(57.14)** | **(57.81)** | **(0.67)** |
| **Total Assets Employed (Assets + Liabilities)** | **231.83** | **220.87** | **(10.96)** |
| **Reserves** | | | |
| Public Dividend Capital | 205.68 | 200.38 | (5.30) |
| Revaluation | 61.35 | 62.09 | 0.74 |
| Income and Expenditure | (35.21) | (41.61) | (6.40) |
| **Total** | **231.83** | **220.87** | **(10.96)** |

- Non-Current Assets are **(£6.2m)** lower than plan. This is largely due to FY22/23 property revaluation having been **(£7.1m)** lower than planned.
- Cash & Cash Equivalents is **(£12.0m)** higher than plan, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are **£16.5m** higher than plan. This is principally due to accrued funding **£12.1m** for the FY22/23 retrospective pay award, payment is due in M03.
- Trade and Other Payables are **£28.0m** higher than plan. This is principally due to the FY22/23 retrospective pay award **£12.1m**, annual leave accrual **£3.2m**, FY23/24 pay inflation top-up **£2.7m** and provider to provider recharges **£8.0m**.
- Other Current Liabilities are **£4.4m** higher than planned including; NHSE (formerly HEE) funding of **£1.4m** received in advance.
- PDC reserves are **£5.3m** lower than planned, due to PDC support being drawn down later than planned.
- The Income and Expenditure reserve is **£6.4m** lower than plan, principally due to below-the-line asset impairment processed late in FY22/23.

# Risks & Mitigations

| Ref | Risk Description | Risk £'000 | R.A.G |
|---|---|---|---|
| R01 | Additional cost risk (capacity, pressures, winter) | 3,000 | |
| R02 | High cost drugs growth | 2,500 | |
| R03 | Efficiency risk | 17,203 | |
| R04 | Income risk (excl. ERF) | 6,100 | |
| R05 | Liberty Protection Safeguard | 1,800 | |
| R06 | Diagnostic Cost Pressure | 1,000 | |
| Total | | 31,603 | |




Highlighted above are the Risks to the Trust's financial position.

- An Efficiency Risk of **£17.203m** has been identified relating to forecast undelivered CIP across the Trust for the year. Actions are being put in place to ensure the overall target of **£46.6m** is delivered in line with plan.

- An Income Risk of **£6.1m** is due to the underachievement of the FY19/20 103% productivity Target.

Torbay and South Devon NHS Foundation Trust

Performance Report - May 2023

| | ISU | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QUALITY LOCAL FRAMEWORK | | | | | | | | | | | | | | | | | |
| Reported Incidents - Severe | Trustwide | <6 | | 3 | 2 | 1 | 3 | 5 | 0 | 0 | 2 | 3 | 1 | 2 | 1 | 1 | 2 |
| Reported Incidents - Death | Trustwide | <1 | | 1 | 0 | 2 | 2 | 1 | 1 | 0 | 0 | 4 | 0 | 1 | 0 | 1 | 1 |
| Medication errors resulting in moderate harm | Trustwide | <1 | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 3 |
| Medication errors - Total reported incidents | Trustwide | N/A | | 60 | 50 | 41 | 59 | 64 | 36 | 44 | 48 | 47 | 44 | 62 | 68 | 72 | 140 |
| Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears) | Trustwide | 9 (full year) | | 0 | 0 | 0 | 0 | 1 | 3 | 1 | 1 | 0 | 3 | 1 | 0 | | 0 |
| Never Events | Trustwide | <1 | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 |
| Strategic Executive Information System (STEIS) (Reported to CCG and CQC) | Trustwide | <1 | | 10 | 8 | 5 | 3 | 2 | 3 | 0 | 6 | 13 | 3 | 13 | 5 | 7 | 12 |
| QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams | Trustwide | <1 | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 2 | 4 |
| Formal complaints - Number received | Trustwide | 20 | | 12 | 12 | 16 | 16 | 10 | 16 | 11 | 10 | 14 | 12 | 12 | 5 | 7 | 12 |
| VTE - Risk Assessment on Admission (acute) | Trustwide | >95% | | 89.7% | 90.0% | 91.8% | 93.6% | 92.7% | 94.7% | 94.4% | 94.0% | 95.5% | 95.9% | 96.5% | 96.3% | 95.4% | 95.9% |
| Hospital standardised mortality rate (HSMR) (3 months in arrears) | Trustwide | <100 | | 117.4 | 117 | 115.1 | 114.7 | 113.4 | 111 | 109.9 | 111.5 | 107.1 | 105.5 | | | | 105.5 |
| Safer staffing - ICO - Day time | Trustwide | 90% - 110% | | 96.1% | 95.8% | 93.7% | 94.4% | 96.4% | 99.1% | 99.4% | 91.6% | 92.1% | 91.3% | 93.1% | 92.4% | 96.0% | 96.0% |
| Safer Staffing - ICO - Nightime | Trustwide | 90% - 110% | | 86.5% | 88.1% | 85.8% | 86.2% | 85.6% | 88.8% | 86.4% | 87.4% | 87.9% | 87.0% | 88.4% | 91.3% | 90.0% | 90.0% |
| Infection Control - Bed Closures - (Acute bed days in month) | Trustwide | <100 | | 12 | 130 | 84 | 36 | 132 | 42 | 156 | 786 | 339 | 254 | 164 | 217 | 120 | 337 |
| Hand Hygiene | Trustwide | >95% | | 92.3% | 94.5% | 96.0% | 97.7% | 96.6% | 94.9% | 96.2% | 91.2% | 94.0% | 92.1% | 91.3% | 92.5% | 92.9% | 92.7% |
| Number of Clostridium Difficile cases (COHA+HOHA) | Trustwide | <3 | | 3 | 4 | 6 | 9 | 6 | 3 | 2 | 1 | 8 | 2 | 2 | 4 | 7 | |
| Fracture Neck Of Femur - Time to Theatre <36 hours | Trustwide | >90% | | 65.8% | 66.7% | 56.4% | 56.0% | 50.0% | 54.3% | 43.3% | 41.5% | 40.0% | 53.8% | 58.3% | 58.0% | 57.1% | 57.1% |
| Stroke patients spending 90% of time on a stroke ward | Trustwide | >80% | | 67.6% | 34.1% | 66.7% | 59.3% | 54.8% | 55.0% | 75.9% | 28.0% | 54.5% | 67.4% | 70.7% | 63.0% | 80.0% | 71.5% |
| Mixed Sex Accommodation breaches | Trustwide | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Follow ups 6 weeks past to be seen date | Trustwide | 6400 | | 22215 | 22158 | 21504 | 21797 | 21821 | 20806 | 20257 | 21452 | 20030 | 20048 | 19979 | 19618 | 19609 | 19609 |
| WORKFORCE MANAGEMENT FRAMEWORK | | | | | | | | | | | | | | | | | |
| Staff sickness / Absence Rolling 12 months (1 month in arrears) | Trustwide | <4.00% | | 5.6% | 5.6% | 5.8% | 5.7% | 5.7% | 5.7% | 5.6% | 5.6% | 4.7% | 5.7% | 5.6% | 5.0% | | 5.0% |
| Appraisal Completeness | Trustwide | >90% | | 73.9% | 75.2% | 77.0% | 78.0% | 75.8% | 76.6% | 77.6% | 76.7% | 77.7% | 76.7% | 76.9% | 77.9% | 78.1% | 78.1% |
| Mandatory Training Compliance | Trustwide | >85% | | 89.8% | 90.1% | 89.7% | 89.2% | 88.7% | 88.6% | 89.1% | 89.7% | 89.9% | 90.1% | 90.4% | 90.7% | 91.2% | 91.2% |
| Turnover (exc Jnr Docs) Rolling 12 months | Trustwide | 10%-14% | | 13.6% | 13.7% | 13.8% | 13.8% | 13.9% | 13.7% | 13.7% | 13.5% | 13.3% | 13.1% | 12.8% | 12.9% | 12.7% | 12.7% |

Torbay and South Devon NHS

Performance Report - May 2023

| | ISU | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COMMUNITY & SOCIAL CARE FRAMEWORK | | | | | | | | | | | | | | | | | |
| Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears) | Trustwide | 6.95% | | | 6.5% | | | 6.8% | | | 6.5% | | | 6.5% | | | |
| DOLS (Domestic) - Open applications at snapshot | Trustwide | NONE SET | | 664 | 705 | 700 | 714 | 737 | 751 | 735 | 756 | 755 | 781 | 814 | 784 | | 671 |
| Intermediate Care - No. urgent referrals | Trustwide | 113 | | 222 | 234 | 222 | 223 | 205 | 277 | 297 | 299 | 318 | 307 | 298 | 287 | 321 | 214 |
| Community Hospital - Admissions (non-stroke) | Trustwide | NONE SET | | 241 | 215 | 234 | 222 | 197 | 193 | 203 | 208 | 198 | 200 | 251 | 224 | 218 | 265 |
| Urgent Community Reponse (2-hour) - Referrals | Trustwide | NONE SET | | 22 | 24 | 25 | 15 | 20 | 26 | 27 | 40 | 34 | 34 | 30 | 26 | 32 | 349 |
| Urgent Community Reponse (2-hour) - Target achievement | Trustwide | 70% | | 77.3% | 66.7% | 88.0% | 80.0% | 85.0% | 100.0% | 74.1% | 77.5% | 79.4% | 94.1% | 90.0% | 92.3% | 90.6% | 81.7% |
| Urgent Community Reponse (2-48 hour)- Referrals | Trustwide | NONE SET | | | | 103 | 195 | 153 | 195 | 196 | 182 | 177 | 171 | 160 | 136 | 155 | 1064 |
| Urgent Community Reponse (2-48 hour) - Target achievement | Trustwide | NONE SET | | | | 78.6% | 86.7% | 86.9% | 85.6% | 86.2% | 84.6% | 92.7% | 83.3% | 86.3% | 87.7% | 87.3% | 83.1% |
| ADULT SOCIAL CARE TORBAY KPIs | | | | | | | | | | | | | | | | | |
| Proportion of clients receiving self directed support - removed from national framework | Trustwide | | | 100.0% | 100.0% | 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 - removed from national framework | Trustwide | 94% | | 100.0% | 100.0% | 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 - removed from national framework | Trustwide | 7% | | 7.3% | 7.3% | 7.5% | 7.5% | 7.6% | 7.9% | 7.9% | 7.8% | 7.9% | 7.8% | 7.8% | 7.4% | | 7.3% |
| % Adults with learning disabilities in settled accommodation - removed from national framework | Trustwide | 80% | | 81.2% | 80.3% | 79.7% | 79.7% | 79.6% | 79.1% | 78.7% | 78.8% | 78.4% | 79.0% | 79.0% | 79.0% | | |
| Permanent admissions (18-64) to care homes per 100k population | Trustwide | 14 | | 29.9 | 35.3 | 28.5 | 40.8 | 32.6 | 27.2 | 29.9 | 32.6 | 32.6 | 28.5 | 29.9 | 32.6 | 27.2 | 24.5 |
| Permanent admissions (65+) to care homes per 100k population | Trustwide | 450 | | 823.8 | 880.4 | 928.8 | 939.6 | 931.5 | 861.5 | 901.9 | 915.4 | 840 | 802.3 | 826.5 | 805 | 748.5 | 576.2 |
| Proportion of clients receiving direct payments | Trustwide | 25% | | 19.4% | 19.6% | 19.7% | 20.0% | 20.4% | 20.3% | 20.2% | 20.3% | 20.0% | 20.2% | 19.5% | 20.1% | 20.1% | 19.5% |
| % reablement episodes not followed by long term SC support | Trustwide | 83% | | 86.8% | 89.6% | 89.5% | 85.4% | 85.2% | 86.0% | 85.5% | 85.4% | 86.6% | 86.4% | 86.4% | 85.3% | 88.3% | 84.5% |
| NHS I - OPERATIONAL PERFORMANCE | | | | | | | | | | | | | | | | | |
| UEC - patients seen within 4 hours (23/24 plan target 76%) | Trustwide | 76% | | 57.6% | 54.5% | 58.5% | 59.1% | 60.2% | 57.0% | 59.4% | 51.8% | 60.0% | 56.9% | 57.6% | 61.7% | 60.8% | 61.3% |
| Referral to treatment - % Incomplete pathways <18 wks | Trustwide | >92% | | 52.3% | 50.6% | 49.5% | 48.5% | 42.5% | 45.5% | 45.5% | 43.3% | 43.9% | 44.3% | 48.1% | 49.7% | 49.8% | 49.8% |
| Cancer - 62-day wait for first treatment - 2ww referral | Trustwide | >85% | | 61.5% | 56.4% | 60.4% | 57.0% | 60.8% | 64.2% | 54.5% | 63.1% | 47.2% | 47.1% | 63.2% | 66.8% | 54.7% | 54.7% |
| Diagnostic tests longer than the 6 week standard | Trustwide | <1% | | 32.0% | 30.1% | 29.1% | 33.9% | 34.9% | 32.4% | 30.1% | 29.0% | 34.0% | 26.1% | 29.7% | 29.8% | 27.7% | 27.7% |
| Dementia - Find - monthly report | Trustwide | >90% | | 94.6% | 84.1% | 92.5% | 90.6% | 94.1% | 87.2% | 93.0% | 91.6% | 87.9% | 84.5% | 87.1% | 83.6% | 90.7% | 83.6% |

Torbay and South Devon NHS Foundation Trust

Performance Report - May 2023

| | ISU | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LOCAL PERFORMANCE FRAMEWORK 1 | | | | | | | | | | | | | | | | | |
| Number of Clostridium Difficile cases (COHA+HOHA) | Trustwide | <3 | | 3 | 4 | 6 | 9 | 6 | 3 | 2 | 1 | 8 | 2 | 2 | 4 | 7 | 11 |
| Cancer - Two week wait from referral to date 1st seen | Trustwide | >93% | | 60.9% | 35.6% | 31.9% | 38.4% | 45.3% | 63.8% | 58.4% | 67.4% | 76.3% | 82.6% | 76.0% | 55.9% | 74.1% | 74.1% |
| Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients | Trustwide | >93% | | 77.8% | 41.7% | 17.3% | 58.5% | 79.1% | 87.7% | 82.8% | 100.0% | 93.5% | 97.6% | 88.9% | 87.9% | 76.7% | 76.7% |
| Cancer - 28 day faster diagnosis standard | Trustwide | 75% | | 67.6% | 64.8% | 67.7% | 72.1% | 70.4% | 75.5% | 69.8% | 74.8% | 71.6% | 77.4% | 77.4% | 74.8% | 80.3% | 80.3% |
| Cancer - 31-day wait from decision to treat to first treatment | Trustwide | >96% | | 90.7% | 96.0% | 96.7% | 98.0% | 92.8% | 96.4% | 89.0% | 98.3% | 95.5% | 98.3% | 95.9% | 89.7% | 92.3% | 92.3% |
| Cancer - 31-day wait for second or subsequent treatment - Drug | Trustwide | >98% | | 98.3% | 100.0% | 97.4% | 100.0% | 98.7% | 100.0% | 90.4% | 98.6% | 100.0% | 100.0% | 100.0% | 98.6% | 100.0% | 100.0% |
| Cancer - 31-day wait for second or subsequent treatment - Radiotherapy | Trustwide | >94% | | 92.6% | 95.5% | 98.0% | 98.4% | 92.2% | 94.4% | 98.0% | 100.0% | 85.7% | 100.0% | 86.9% | 100.0% | 96.9% | 96.9% |
| Cancer - 31-day wait for second or subsequent treatment - Surgery | Trustwide | >94% | | 95.5% | 87.5% | 88.9% | 95.5% | 96.8% | 89.7% | 86.8% | 89.7% | 80.0% | 96.2% | 83.3% | 88.5% | 87.5% | 87.5% |
| Cancer - 62-day wait for first treatment - screening | Trustwide | >90% | | 66.7% | 92.9% | 69.2% | 70.0% | 90.9% | 100.0% | 81.0% | 76.9% | 100.0% | 100.0% | 72.7% | 100.0% | 100.0% | 100.0% |
| Cancer - Patient waiting longer than 104 days from 2ww (Improvement target 20) | Trustwide | | | 59 | 60 | 73 | 37 | 43 | 71 | 62 | 69 | 68 | 53 | 24 | 20 | 11 | 11 |
| RTT 65 week wait incomplete pathway | Trustwide | 1091 | | 1824 | 1855 | 1789 | 2093 | 2252 | 2485 | 2174 | 2203 | 1828 | 1679 | 1372 | 1244 | 1168 | 1168 |
| RTT 78 week wait incomplete pathway | Trustwide | 178 | | 813 | 713 | 686 | 787 | 813 | 829 | 822 | 923 | 708 | 462 | 183 | 166 | 167 | 167 |
| RTT 104 week wait incomplete pathway | Trustwide | 0 | | 173 | 96 | 70 | 51 | 50 | 47 | 34 | 29 | 22 | 14 | 0 | 0 | 0 | 0 |
| On the day cancellations for elective operations | Trustwide | <0.8% | | 1.1% | 1.3% | 1.7% | 3.1% | 1.4% | 1.7% | 1.5% | 2.1% | 1.4% | 1.5% | 1.5% | 0.8% | 1.4% | 1.1% |
| Cancelled patients not treated within 28 days of cancellation | Trustwide | 0 | | 5 | 9 | 9 | 13 | 8 | 7 | 15 | 6 | 11 | 10 | 7 | 7 | 10 | 17 |
| Virtual outpatient appointments (non-face-to-face) | Trustwide | 25% | | 20.9% | 20.9% | 20.2% | 16.9% | 16.8% | n/a | 16.6% | 16.1% | 16.5% | 15.3% | 14.6% | 15.8% | 15.2% | |
| Bed Occupancy | Acute | 90.0% | | 95.1% | 93.7% | 93.2% | 94.3% | 92.3% | 92.3% | 95.2% | 94.9% | 96.3% | 96.2% | 96.3% | 95.3% | 96.4% | 94.5% |
| Percentage of inpatients with No Criteria to Reside (acute) | Trustwide | <5% | | | | | | 12.0% | 11.0% | 11.0% | 13.0% | 13.0% | 12.0% | 8.1% | 7.6% | 6.0% | |
| % patient discharges pre-noon | Acute | 33% | | | | | | | | 23.6% | 18.1% | 19.0% | 18.5% | 19.2% | 18.9% | 18.9% | |
| % patient discharges pre-5pm | Acute | 75% | | | | | | | | 67.2% | 63.2% | 65.2% | 67.9% | 67.3% | 69.8% | 66.7% | |
| Number of patients >7 days LoS (daily average) | Trustwide | | | 166.0 | 173.0 | 167.0 | 167.0 | 184.9 | 177.0 | 162.0 | 172.6 | 183.5 | 166.1 | 167.0 | 154.2 | 159.8 | 157.0 |
| Number of extended stay patients >21 days (daily average) | Trustwide | | | 38.5 | 43.0 | 40.9 | 48.0 | 49.2 | 49.8 | 32.0 | 42.3 | 57.1 | 40.7 | 38.6 | 39.3 | 33.2 | 36.3 |
| LOCAL PERFORMANCE FRAMEWORK 2 | | | | | | | | | | | | | | | | | |
| Ambulance handover delays > 30 minutes | Trustwide | Trajectory | | 909 | 1886 | 1476 | 1156 | 1012 | 1208 | 1112 | 1232 | 865 | 534 | 1043 | 598 | 1025 | 1623 |
| Ambulance handover delays > 60 minutes | Trustwide | 0 | | 527 | 1458 | 1078 | 871 | 764 | 933 | 787 | 983 | 623 | 263 | 687 | 277 | 595 | 872 |
| ED - patients with >12 hour visit time pathway | Trustwide | | | | 871 | 827 | 920 | 906 | 988 | 939 | 1207 | 823 | 599 | 977 | 568 | 891 | 1459 |
| Time to Initial Assessment % seen within 15 mins - Emergency Department | Acute | | | | 37% | 36% | 36% | 39% | 37% | 39% | 31% | 46% | 44% | 41% | 52% | 53% | 53% |
| Clinically Ready to Proceed delay over 1 hour - Emergency Department | Acute | | | | | | | | 40% | 44% | 39% | 42% | 40% | 44% | 41% | 40% | 40% |
| Non-admitted minutes mean time in Emergency Department (hh:mm) | Acute | | | | 05:16 | 05:06 | 05:05 | 04:51 | 05:21 | 05:14 | 06:05 | 05:02 | 04:53 | 05:08 | 04:24 | 04:42 | |
| Admitted minutes mean time in Emergency Department (hh:mm) | Acute | | | | 12:44 | 12:15 | 12:15 | 14:22 | 14:06 | 13:14 | 16:05 | 13:42 | 10:06 | 12:47 | 09:10 | 11:15 | |
| CDiff - Hospital Onset Healthcare Associated (HOHA) | Trustwide | | | 3 | 4 | 4 | 5 | 3 | 2 | 0 | 1 | 7 | 1 | 1 | 3 | 4 | 7 |
| CDiff - Community Onset Healthcare Associated (COHA) | Trustwide | | | 0 | 0 | 2 | 4 | 3 | 1 | 2 | 0 | 1 | 1 | 1 | 1 | 3 | 4 |
| Care Planning Summaries % completed within 24 hours of discharge - Weekday | Trustwide | >77% | | 71.0% | 63.8% | 69.7% | 70.7% | n/a | 69.1% | n/a | 48.9% | 72.3% | 65.7% | 58.1% | 65.0% | 61.5% | 63.2% |

Torbay and South Devon NHS Foundation Trust

Performance Report - May 2023

| | ISU | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Planning Summaries % completed within 24 hours of discharge - Weekend | Trustwide | >60% | | 52.2% | 50.8% | 48.0% | 48.3% | n/a | 47.4% | n/a | 41.5% | 48.1% | 45.1% | 39.4% | 49.1% | 55.5% | 52.0% |
| Clinic letters timeliness - % specialties within 4 working days | Trustwide | >80% | | 65.4% | 69.5% | 69.1% | 80.2% | 59.0% | 60.0% | 62.0% | 68.0% | 73.9% | 69.2% | 62.8% | 67.7% | 64.4% | |
| NHS I - FINANCE AND USE OF RESOURCES | | | | | | | | | | | | | | | | | |
| EBITDA - Variance from PBR Plan - cumulative (£'000's) | Trustwide | | | 718 | -914 | -1231 | -4412 | -5783 | -7140 | -10433 | -13434 | -16118 | -19884 | -21358 | -394 | -4478 | |
| Agency - Variance to NHSI cap | Trustwide | | | -2.40% | -2.40% | -2.10% | -2.10% | -2.00% | -1.90% | 1.90% | -1.80% | -1.80% | -1.90% | -1.90% | -2.00% | -2.00% | |
| CIP - Variance from PBR plan - cumulative (£'000's) | Trustwide | | | | | | -3858 | -4403 | -4872 | -5005 | -5874 | -5328 | -5512 | -3390 | -449 | 17 | |
| Capital spend - Variance from PBR Plan - cumulative (£'000's) | Trustwide | | | 1977 | 814 | 1203 | 1065 | 975 | 1988 | 2787 | 3280 | 4076 | 944 | -18162 | -993 | 3619 | |
| Distance from NHSI Control total (£'000's) | Trustwide | | | 1286 | 0 | 0 | -2978 | -4014 | -5022 | -7421 | -9995 | -12182 | -15796 | -17186 | 22 | 307 | |
| ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022) | | | | | | | | | | | | | | | | | |
| Outpatients - New | Trustwide | | | -13.8% | -7.5% | -18.1% | 2.4% | 0.2% | -11.7% | 3.6% | -2.0% | -5.2% | -0.6% | 16.1% | -9.0% | | -56.0% |
| Outpatients - Follow ups | Trustwide | | | -5.5% | -7.0% | -15.3% | 4.0% | -0.8% | -10.1% | 4.4% | -4.1% | -6.9% | -2.4% | 9.0% | -8.6% | | -55.5% |
| Daycase | Trustwide | | | -10.4% | -0.4% | -7.9% | -3.5% | 3.2% | -4.6% | -3.0% | -5.5% | -1.7% | 5.1% | 21.7% | -14.3% | | -59.1% |
| Inpatients | Trustwide | | | -8.8% | -7.0% | -16.1% | -15.5% | 9.6% | -16.3% | -19.5% | -21.4% | -18.1% | -16.4% | 42.0% | -16.2% | | -60.8% |
| Non elective | Trustwide | | | -11.5% | -1.4% | -8.2% | -2.9% | -7.1% | -7.0% | -12.7% | -18.1% | -5.7% | -11.2% | -0.2% | -7.1% | | -54.7% |

| | Target | 13 month trend | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA | | | | | | | | | | | | | | | | |
| Urgent and Emergency Care | | | | | | | | | | | | | | | | |
| Percentage of Ambulance handovers greater than 15 minutes | | | 69.6% | 80.0% | 77.0% | 78.3% | 77.5% | 84.4% | 82.2% | 87.5% | 66.5% | 54.8% | 73.9% | 55.4% | 72.1% | 55.4% |
| Total average time in ED (hours/minutes) | | | 06:23 | 07:22 | 07:02 | 07:06 | 07:33 | 07:58 | 07:44 | 08:59 | 07:49 | 06:35 | 07:34 | 05:57 | 06:48 | 05:57 |
| ED attendances where visit time over 12 hours | 0 | | 668 | 871 | 827 | 920 | 906 | 988 | 939 | 1207 | 823 | 599 | 977 | 568 | 891 | |
| UEC 4-hour target (RAG against local trajectory to national target) | 76% | | 57.6% | 54.5% | 58.5% | 59.1% | 60.2% | 57.0% | 59.4% | 51.8% | 60.0% | 56.9% | 57.6% | 61.7% | 60.8% | |
| % patient discharges pre-noon | 33% | | | | | | | 18.4% | 23.6% | 18.1% | 19.0% | 18.5% | 19.2% | 18.9% | 18.9% | 18.9% |
| Percentage of inpatients with No Criteria to Reside (acute) | <5% | | | | | 17.0% | 12.0% | 11.0% | 11.0% | 13.0% | 13.0% | 12.0% | 8.1% | 7.6% | 6.0% | 7.6% |
| Elective recovery | | | | | | | | | | | | | | | | |
| RTT 104 week wait incomplete pathway | 0 | | 173 | 96 | 70 | 51 | 50 | 47 | 34 | 29 | 22 | 14 | 0 | 0 | 0 | 0 |
| RTT 78 week wait incomplete pathway | 176 | | 813 | 713 | 686 | 787 | 813 | 829 | 822 | 923 | 708 | 462 | 183 | 166 | 167 | 166 |
| RTT 65 week wait incomplete pathway | 1091 | | | | | 2093 | 2252 | 2485 | 2174 | 2203 | 1828 | 1679 | 1372 | 1244 | 1168 | 1244 |
| RTT 52 week wait incomplete pathway | | | 3765 | 4137 | 4578 | 5083 | 5060 | 5412 | 5585 | 6027 | 5554 | 5116 | 4427 | 4024 | 3926 | 4024 |
| Patient waits over 2.5 years | 0 | | 32 | 48 | 54 | 47 | 24 | 24 | 17 | 12 | 9 | 6 | 0 | 0 | 0 | 0 |
| 75% of GP referred patients diagnosed within 28 days | 75% | | 67.6% | 64.8% | 67.7% | 72.1% | 70.4% | 75.5% | 69.8% | 74.8% | 71.6% | 77.4% | 77.4% | 74.8% | 80.3% | 74.8% |
| Number of patients waiting longer than 62 days for treatment | 138 | | 307 | 233 | 283 | 244 | 333 | 331 | 229 | 253 | 225 | 130 | 114 | 107 | 111 | 107 |

NHS
Torbay and South Devon
NHS Foundation Trust

| **Report to the Board of Directors** | | | |
|---|---|---|---|
| **Report title**: Annual Report 2022/23 | | | **Meeting date:** 28th June 2023 |
| **Report appendix** | Appendix 1 – Clean Annual Report<br>Appendix 2 – Tracked changed Annual Report, showing changes since meeting on 20 June 2023 | | |
| **Report sponsor** | Director of Corporate Governance & Trust Secretary | | |
| **Report author** | Director of Corporate Governance & Trust Secretary | | |
| **Report provenance** | Audit and Risk Committee – 24th May 2023<br>Board of Directors – 13th June 2023<br>Board of Directors – 20th June 2023<br>Audit and Risk Committee – 27th June 2023 | | |
| **Purpose of the report and key issues for consideration/decision** | Please find enclosed a final draft of the annual report and accounts for year ended 31 March 2023. The annual report has previously been reviewed and discussed by both the Trust Board of Directors and Audit and Risk Committee.<br>The Trust is required to submit the annual report to NHSE by noon on Friday 30th June 2023.<br>The Annual report (and accounts) are then required to be laid before Parliament by Friday 7th July 2023. | | |
| **Action required (choose 1 only)** | **For information** ☐ | **To receive and note** ☐ | **To approve** ☒ |
| **Recommendations** | The Board of Directors is asked to approve the 2022/23 Annual Report in order that they can be submitted to NHSE by noon on Friday 30th July 2023.<br>The Board are further asked that any minor changes to be made following their review on 28 June be delegated to the Chairman and Chief Executive; such changes must not be material. | | |
| **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 | |

Public

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

Our Trust

# Annual Report and Accounts 2022/23

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## FOREWORD BY THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome to our Annual Report for 2022/23. As we look back on another challenging year for the NHS, we are hopeful for what the future may bring for our people and our communities.

As the largest employer in Torbay and South Devon we take our role as an anchor institution very seriously. We are much more than the services we provide, delivering better health and care for all encompasses not only the provision of clinical services, but in acknowledging our role within the locality and communities we operate within; both economically and environmentally. Not only are we able to offer local people opportunities to work with us, but care for the local environment as a significant landowner as well as supporting local businesses through our procurement and purchasing.

Turning to the operational environment we find ourselves within; it is over three years since the World Health Organisation declared COVID-19 a pandemic and during that time the NHS has been challenged as never before in its 75-year history. One of the outcomes of COVID-19 has been the delay of service delivery in some areas. This has led to longer waiting lists for care and treatment, which combined with a tired workforce has been challenging. This has however encouraged us to consider new ways of working, pushing us to be more innovative and creative. It has also given us moments of joy, encouraging communities to come together to care for and support each other as well as creating opportunities for us to deliver care in different ways, improving experiences and outcomes.

During the year we were placed in segment 4 of the system oversight framework (SOF) set by NHS England, our regulator and operating licence issuing body. This framework prescribes their approach to regulatory oversight and intervention dependent on financial and operational performance. All acute providers in Devon and the Devon system are currently in segment 4 as a result of our financial and operational performance challenges. We are committed to working together with our people to address our challenges and to deliver better care and better value for our communities.

Noting the above, over the past twelve months we have however witnessed emerging signs of recovery in our services, our teams and our people. Our highlights this year included the opening of our new Acute Medical Unit at Torbay Hospital, which is helping to transform how we provide urgent and emergency care. Thanks to the generosity of our Brixham Hospital League of Friends, our GP partners are now able to provide primary care services from the hospital site, with the opening of branch surgeries. We also saw the progress toward completion of the new purpose-built health and wellbeing centre in Dartmouth; which has since opened, with a successful launch event in May 2023.

Many of the challenges we face are not unique. Working together with our health and care partners in the Devon and Cornwall peninsula is key to us providing better health and care for all, ensuring that everyone has access to the care they need, when they need it. Further detail of our successes and challenges can be found within the Performance report and supporting analysis, pages x to x.

To that end, whilst we have always been committed to partnership working, this year we have further increased our focus on collaboration within Devon. One example of this is our role within the Peninsula Acute Sustainability programme; whose focus is

to secure sustainable acute services now and into the future, starting with a review of our fragile services. Together we are working to ensure that we get the best value for every pound that we spend, while doing those things together that make sense, reducing duplication and waste and enabling us to reduce waiting times and improve patient experience and outcomes.

As an organisation we are committed to improving and delivering excellent, high quality, safe care to people who use our services. We passionately believe that the best way to care for people is by focussing on what matters to them, empowering them in their own care and integrating services around them. We believe that care as close to home as possible benefits everyone. This remains at the heart of our vision and our strategy as an integrated care organisation.

We couldn't do any of this without our amazing people. The last few years have taken a toll on all of us, and our dedicated, talented and caring people have experienced significant pressure and stress. We know that people who are fulfilled and valued provide better care and have the energy to develop new ideas and ways of working. Through our people promise, we are working with our staff to create a workplace where each and every one can thrive. We would therefore like to take this opportunity to thank our wonderful people, our volunteers, our governors and members, our many friends from our hospital leagues, nurses' league and other supporters, our fundraisers and our partners. It will take all of us to achieve our vision of better health and care for all, but we believe that we can do this, together.

As we look to the future, we plan to continue the positive progress made this year in developing our care model and reducing waiting times across both urgent and emergency and planned care services. We look forward to preparing our Torbay Hospital site for our new hospital and developing our integrated care model. Our new hospital facilities will be supported by local health and wellbeing centres and home-based care, making the most of digital technology to deliver better health and care for all.

Thank you once again for all your support this year and for what we hope will be your continued involvement, engagement and support as we look forward to the next 75 years of the NHS and our brighter future.

| | |
|---|---|
| Richard Ibbotson | Liz Davenport |
| KBE CB DS CDL<br>Chairman<br>28 June 2023 | Chief Executive<br><br>28 June 2023 |

# INTRODUCTION, PURPOSE AND HISTORY

## Our purpose and activities

We are proud pioneers in integrated health and social care. Our purpose is to support the people of Torbay and South Devon to live well and we aim to achieve this by focusing on excellent population health and wellbeing, excellent experience in receiving and providing care, and excellent value and sustainability.

Improvement and innovation are central to what we do, both in terms of our integrated care services and our specialist clinical services, for example day surgery being nationally recognised for their best practice.

We live and work in a beautiful part of the West Country which is a very popular tourist destination. Our population reflects that of many coastal communities, with a significant level of health inequality and high levels of deprivation. Torbay itself is one of the most highly deprived communities in the south west. The impact of COVID-19 has both increased the pressure across all aspects of health and social care, and increased health inequalities for those who live in our most deprived coastal communities.

We have a low wage and low skill local economy, with a heavy reliance on tourism and not enough opportunities for our young people. Many of our children start their lives at a disadvantage. We have high numbers of looked after children and children with protection arrangements in place.

Poverty and deprivation are key determinants of health and as a result we see significantly more alcohol and self-harm related admissions and poorer mental health and physical health outcomes.

We have a larger proportion of older people than the national average and, due to our area's attractiveness as a retirement location, we expect to see this increase. Many of our older people are living with long-term conditions which results in a greater demand for older people's health and care services, with FEWER young people in our labour market to provide care.

We passionately believe that supporting people to manage their own health and wellbeing is a critical factor in helping them to have better health outcomes and to live well. We do this by focusing on what matters to them and providing personalised, compassionate care as close to home as possible.

We work with many different communities: our patients and their carers, families and friends, our staff, members and governors, care home and domiciliary care providers, our NHS colleagues in Devon and the wider south west as well as colleagues in the private sector, and our public and voluntary sector partners.

Working together, we share and learn from our combined experience and expertise so we can provide the very best care and services for our local people, whenever they need us.

We serve our local people by providing community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites.

More and more we are delivering care directly into people's homes either through visits or online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in two community locations. Owing to sustained recruitment difficulties, we have had to reduce the number of community sites offering urgent care – this has meant the temporary closure of our minor injury unit in Dawlish. In summer 2022 we were able to reopen our minor injury unit in Totnes which had been closed since March 2020. The urgent treatment centre in Newton Abbot has remained open 7 days a week and offers an x-ray service.

We work in partnership with the communities and the voluntary sector to help people to get home from hospital when they no longer need clinical care and wrap services and support around them to help combat loneliness and isolation and avoid readmission to hospital. We are committed to continuing to support this type of help and will commission a longer-term contract for this type of care and support. In this endeavor, we benefit from the support of 434 active volunteers and work with approximately 89 volunteering for charities.

We support around 300,000 face-to-face contacts with patients in their homes and communities each year and see over 62,459 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

We cover a wide geographical area, including parts of Dartmoor (Newton Abbot, Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes and Dartmouth. We employ over 6,600 staff to deliver and manage our services, from porters to consultants, nurses and health care assistants to ‘hotel’ and catering staff, therapists and security staff….and there are many more! We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

Our operating income for 2022/23 was £644 million. NHS Devon commission our main acute and community services. Devon County Council and Torbay Council commission our adult social care services and our public health nursing services. We have continued to forge many strategic and business partnerships to strengthen and improve our services as detailed below:

- we are the lead organisation in the alliance with Devon Partnership Trust, through which we provide Children and Family Health Devon (CFHD) since April 2018. Our other alliance members are NHS partners Royal Devon University Healthcare NHS Foundation Trust, Devon Partnership NHS Trust and social enterprise Livewell Southwest
- we have a wholly owned subsidiary (SDH Developments Limited) providing an on-site pharmaceutical dispensary at Torbay Hospital
- we are a partner in a Limited Liability Partnership (SDH Innovations Partnership LLP), which supports our ambitions to replace out-of-date facilities with new buildings
- we are part of University of Exeter’s Academy of Nursing, along with other Devon NHS providers
- through Torbay Clinical School, we promote clinical research in partnership with Plymouth University

- more recently, we became a partner in the Peninsula Acute Sustainability Programme (PASP) with University Hospitals Plymouth NHS Trust, Royal Devon University Healthcare NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust which supports us to collaborate to secure sustainable, high-quality care for everyone for the future
- in 2021, we became a core part of the South Local Care Partnership with our NHS, council and voluntary sector partners. There are five local care partnerships across the county which form a key part of the Devon Integrated Care System
- we are continuing to forge closer partnership with South Devon College to align our workforce and education strategies.

Looking ahead, we have been given a share of £20 billion government funding for a new hospital development. This is a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people. It is not just about building a better hospital in Torquay. It is about building a brighter future for all of us.

We are exploring opportunities to deliver our services in ways that provide better outcomes for our population and better working environments for staff across all the communities that we serve and further building on our integrated approach to service delivery, led and shaped by our health and care model.

## Our history and statutory background of the Foundation Trust

Torbay and South Devon Foundation Trust ("the Foundation Trust or Trust") was established as a public benefit corporation and integrated care organisation, following its approval as an NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts authorised under the Health and Social Care (Community Health and Standards) Act 2006 on 01 October 2015.

The principal location of the business is Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA. Our licence registration number with NHS England is: 110102

In addition to the above, we have registered the following locations with the Care Quality Commission:

- Ashburton and Buckfastleigh Hospital, Eastern Road, Ashburton TQ13 7AP
- Brixham Hospital, Greenswood Road, Brixham TQ5 9HN
- Brunel Dental Centre, Brunel Industrial Estate, Newton Abbot TQ12 4XX
- Castle Circus Health Centre, Abbey Road, Torquay TQ2 5YH
- Dartmouth Clinic, Mayors Avenue, Dartmouth TQ6 9NF
- Dawlish Hospital, Barton Terrace Dawlish EX7 9DH
- Kingsbridge Hospital (South Hams) Special Care Dental, Plymouth Road, Kingsbridge TQ7 1AT
- Newton Abbot Hospital, Jetty Marsh Road, Newton Abbot TQ12 2TS
- Paignton Hospital, Church Street, Paignton TQ3 3AG
- St Edmunds Victoria Park Road, Torquay TQ1 3QH
- Tavistock Special Care Dental Service, 70 Plymouth Road, Tavistock PL19 8BX
- Teignmouth Hospital, Mill Lane, Teignmouth TQ14 9BQ
- Torbay Hospital, Newton Rd, Torquay TQ2 7AA
- Totnes Hospital, Coronation Road, Totnes TQ9 5GH
- Walnut Lodge, Walnut Road, Torquay TQ2 6HP

We are registered with the Care Quality Commission without conditions and provides the following regulated activities across the stated locations:

- assessment or medical treatment for persons detained under the 1983 Act
- diagnostic and screening procedures
- family planning services
- 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.

As a Foundation Trust responsible for public funds, the Board of Directors is accountable to a range of stakeholders and crucially the local people that use our services. Our local population is formally represented within our governance structure by the Council of Governors. Governors are elected from each constituency, with the number of positions weighted by the population living in the locality. Full guidance on how Foundation Trusts are required to operate is available from NHS England.

## Our values and the NHS Constitution

At our core, we are deeply connected to, and rooted in, the values of the NHS. We work together for patients and our communities.

We have adopted the NHS constitution values which apply across the NHS in England. Patients, public and staff developed these together. Our shared NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Our values are:

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- working together for people
- everyone counts.

Our people promise is our commitment to each other, including how we enhance our own behaviours which will help us demonstrate and deliver the NHS values. We know that a good staff experience leads to a good patient experience, and our people promise is a framework to ensure every aspect of our experience working in the NHS is nurtured. By looking after our staff, we continually work to ensure our values are upheld.

Our people promise priority is to build a healthy culture at work where our people feel safe, healthy and supported, in order to achieve all the different components of the NHS people promise :

- we are a team
- we are safe and healthy
- we are compassionate and inclusive
- we each have a voice that counts
- we work flexibly
- we are always learning
- we are recognised and rewarded.

To deliver our People Promise, we are focusing on designing a consistent, compassionate leadership approach that is inclusive, motivating and empowering; creating an environment of kindness and respect; and making people's lives easier by freeing up time to work in a safe and calm manner on agreed priorities.

Our People Awards are based on our people promise, recognising and rewarding our people for living our people promise and our values.
Our people promise and values underpin how we want to work together, by doing so we can support better health and care for all.

## Our partners

Our purpose to support the people of Torbay and South Devon to live well is delivered in partnership with local organisations and communities. We do this by working with our South Local Care Partnership (LCP) and across our wider Integrated Care System, with health and care providers across Devon.

At a local level we have strong relationships with our local GPs and primary care, Devon County and Torbay Councils, the local community voluntary sector and our independent sector partners who provide much needed care home support and domiciliary care. We work closely with our local councils and the business community to improve the wider determinants of health and recently signed a memorandum of understanding to be an active partner in community wealth building.

We are clear about our leadership role in our local health and care system. As an anchor institution we are deeply connected to our local area and we use our influence, skills and resources to benefit the communities we serve.

We recognise the challenge of both maintaining and developing our own organisation while contributing and collaborating to improve the health and wellbeing of everyone, not only in Torbay and South Devon but in the county of Devon as a whole.

## Integrated Care System – the Devon long-term plan

NHS Devon (the integrated care board) has developed its Joint Forward Plan (JFP) in collaboration with the five local care partnerships and three health and wellbeing boards in the county.

The plan, which is to be submitted by June 2023, will set out how the system will work together, to deliver transformational change and improve the health and wellbeing of the population.

It includes nine areas of focus:

1. primary and community care
2. mental health, learning disabilities and neurodiversity
3. women and children
4. acute services
5. housing
6. community development
7. employment
8. health protection
9. suicide prevention

The JFP is a response to the Integrated Care Strategy, which was published in draft on the One Devon website in January 2023. NHS, local authority, and other partners were all involved in producing the strategy which was coordinated by the One Devon Partnership (the integrated care partnership).

The Devon system is currently in level four of the System Oversight Framework (SOF4) due to finance and performance issues, which brings with it enhanced direct oversight by NHS England and additional reporting requirements and financial controls. The JFP therefore reflects the need to focus on system recovery and exiting SOF4 as priority.

A summary of the SOF4 exit criteria are listed below, with an estimated exit date of 2024/25:

- urgent and emergency care – make progress against national objectives
- elective recovery – make progress against national objectives
- finance – develop and deliver realistic balanced plan for 2023/24
- leadership – demonstrate collaborative decision-making
- strategy – deliver phase one of the Peninsula Acute Sustainability Programme (PASP).

Partners across the county continue to work together in many areas, including the PASP. PASP sees clinicians and staff from across Devon, Cornwall and Isles of Scilly working together to ensure the clinical, workforce and financial sustainability of acute services.

A series of workshops have been underway since December 2022 to review and redesign acute services, initially beginning with paediatric assessment, medical assessment, and surgical assessment.

# Part I –PERFORMANCE REPORT, OVERVIEW, RISK & ANALYSIS

## PERFORMANCE OVERVIEW & RISK POSITION

### Summary of our performance

The purpose of this section is to provide information about our organisation, our purpose and main objectives, the key risks to the achievement of our objectives, and how we have performed during the year. More detailed information on the arrangements in place and our approach to ensure services are well-led is given in the Performance Analysis Report and the Annual Governance Statement.

In this section, we highlight the main developments in our services and the improvements we have made over the past twelve months. We also report our performance against key national and locally determined clinical standards.

This report outlines our position on 31 March 2023 and provides commentary on relevant post year-end matters.

### Chief Executive's statement on performance

The pressures of meeting the health and social care needs of a growing and diverse population, alongside large changes to the infrastructure of the NHS, in a difficult financial climate have been significant; as you will see within our performance data, which shows both our challenges and our emerging signs of recovery. Our performance is assessed against a range of national targets and standards and is reported externally.

With regard to National priorities, these are outlined in the 2022/23 operational planning guidance and include: investing in the workforce, responding to COVID-19 ever more effectively; delivering significantly more elective care to tackle the elective backlog; improving the responsiveness of urgent and emergency care (UEC) and building community care capacity; improving timely access to primary care; improving mental health services and services for people with a learning disability and/or autistic people; continuing to develop our approach to population health management, preventing ill-health and addressing health inequalities; exploiting the potential of digital technologies; making the most effective use of our resources; and establishing ICBs (Integrated Care Boards) and collaborative system working.

An assessment of our progress against these, and performance more generally, can be found within the Performance report and supporting analysis, below. Supporting analysis and commentary are provided with trend charts showing the position over the previous five quarters or fifteen months, depending on the frequency of the measurement period.

For their oversight and assurance during the year, the Board of Directors considered an Integrated Performance Report at each meeting which described performance against these targets and any action being taken to address dips in performance. This is informed by detailed review at Executive, Care Group and Committee level prior to each Board meeting.

In addition, the Integrated Service Units ('ISUs'), each of which is responsible for delivering services to their localities (Coastal, Moor to Sea, Newton Abbot, Paignton and Brixham, and Torquay) reviewed quality and performance dashboards relevant to their services monthly and to present plans where there were risks or concerns.

There was also detailed scrutiny of the different elements of the Integrated Performance Report through the Finance, Performance and Digital Committee, People Committee and Quality Assurance Committee. At each financial quarter end, the Board confirms the position of each of these metrics to NHS England. Details of our performance during the year can be seen below.

## PERFORMANCE OVERVIEW CONTINUED: OUR HIGHLIGHTS, OUR CHALLENGES & RISK PROFILE, OUR SUCCESSES, OPPORTUNITES & OUR KEY EVENTS

Below is a summary of our highlights and risk position, noting our challenges, our opportunities and context within the Devon locality.

### Our year in highlights 2022-23

It has been another tough and challenging year. We have experienced sustained demand for services whilst managing a challenging landscape for delivery, which has been impacted by COVID-19 as well as those who sought treatment delayed due to the pandemic, seasonal illnesses and industrial action by NHS and other public and private sector workers. Through the commitment of our people and a focus on driving improved performance we are, however, seeing signs of recovery with a reduction in the length of time people are waiting for treatment; although there is still a long way to go to ensure people are seen as quickly as we would wish.

Partnership is and remains central to our ethos; both as an integrated care organisation and committed partner within the Devon Integrated Care System. You will see this as a key theme when describing our performance and service improvement measures taken during this and into the next financial year. Our dedicated people have been central to this as well as those working across NHS Devon and our key stakeholders; whose approach to collaborative working has provided a real opportunity to listen, learn and help us scope delivery for our vision of better health and care for all.

Despite the progress we have made, during the year,we were placed in segment 4 of the system oversight framework (SOF) by NHS England. All acute providers in Devon and NHS Devon are in segment 4 due to our financial and performance challenges. We are working together with our system partners to:

- improve how we deliver care, in line with best practice and the latest evidence
- improve our levels of activity so fewer people wait for care
- make sustainable, affordable improvements that put us in the best position to secure the investment we need to continue to deliver better care
- deliver the best value we can to our people and communities while managing our available monies effectively and balancing our books.

We have developed a clear plan that will support us to deliver the level of improvement required to move from SOF4 to SOF3 by the end of 2023/24, in the hopes that this will support the system to move out of SOF4. Our aim is to deliver safe, sustainable, and affordable services that provide the best care, outcomes, and experiences we can. We want to deliver the best value we can while supporting our people to deliver care they can be proud of and providing a great place to work.

## Our challenges and risk profile

Our primary challenges and key risks are derived from our financial position, the delipidated state of our physical and digital environments, the quality of services we provide, maintaining our workforce and caring for our people (reducing turnover).

The oversight and management of these is reflected in our business assurance framework which allows us to distill our strategy into key themes (objectives) and manage our risk to delivery, monitoring any gaps in assurance that we will deliver as well as our corporate risk register.

A summary of the challenges we faced in 2022/23, going into 2023/2024 can be found below:

- delivery of a challenging financial plan, including significant savings and productivity initiatives while maintaining a personalised and safe patient experience for all of our users:
    - recovery of activity levels to pre-pandemic levels and beyond, managing and reducing increased waiting lists
    - delivery of an ambitious capital programme
    - challenged workforce capacity and resilience, burnout/fatigue arising from ongoing significant operational pressures risk of lack of talent pipeline and supply, recruitment and retention of staff across specific specialties/professional groups, due to no strategic business or workforce planning
    - creating capacity for learning and development opportunities for our leadership teams and people in general due to the workforce capacity and resilience matters outlined above
    - risk of unaffordable workforce costs due to increased use of bank and agency staff
    - risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
    - risk of inability to build a culture where people feel safe, healthy and supported due to rising number of equality, diversity and inclusion (EDI) related grievances and a reported decline in workplace experience by those with disabilities or from a BAME background.

A detailed analysis of these and our risk management framework can be found within the Annual Governance Statement, pages x to x

## Our successes, priorities and opportunities: strategic delivery

This annual report (year ended March 2023) aligns to the revised strategy adopted by the Board in February 2022, which is reviewed annually. Key activities aligned to our six strategic priorities and intent are:

### Providing more personalised and preventative care: what matters to you matters

An innovation grant awarded for Multiple Sclerosis (MS) augmented reality project to support people with multiple sclerosis to take care of their health.

We have expanded our Health Connect Coaching programme to match volunteer coaches who have lived experience with long term conditions, to help others to take control and manage their own health

### Reducing inequity and building a health community with local partners

Our Torbay adult social care service worked with the voluntary sector to provide support to address the impact of the cost-of-living crisis. Support includes debt management, access to energy advice, employment opportunities and access to community-based support.

### Increasing our fundraising activities to support treatment and care

Health champion Lottie Bryon-Edmond made history when she was made an honorary director of our Board in recognition of her commitment to raising awareness of organ donation and the life-changing contributions of donors and their families.

As well as raising awareness of organ donation, Lottie is tirelessly fundraising for a permanent memorial for organ donors and their families which we hope will be installed in the main entrance of Torbay Hospital soon.

Donations to our charity have once again helped to improve and enhance patient care, funding equipment and projects that are over and above those provided by NHS funding.

We reiterated our commitment to working alongside local, regional, and national fundraising and charitable organisations to, wherever possible, maximise the opportunities to bring in monies that will benefit our local people and communities.

### A relentless focus on quality improvement underpinned by people, process and technology

### Emergency department improvements welcomed

The Emergency Department team have had a real focus on quality improvement, developing a patient journey map to welcome people at the main entrance and in the triage area. The map explains what to expect when patients arrive in ED, the assessment process (based on the urgency of their symptoms or injury) and any required care and treatment they may need. We also installed new signage to direct people to the treatment areas, a TV screen showing information such as waiting times and a graphic showing the range of uniforms worn by different ED staff.

The changes, which are part of a wider patient improvement project to improve people's experiences at the hospital, have been welcomed by our people and visitors.

### Revolutionary radiotherapy trial for people with throat cancer

During the summer we opened a clinical research trial called TORPEdO, where throat cancer patients can benefit from world-class proton beam therapy which uses protons which can release energy at an exact point in the body protecting more healthy tissue and decreases the chance of side effects developing.

Co-led by The Christie NHS Foundation Trust in Manchester and The Institute of Cancer Research in London, this trial will determine whether the use of proton beam therapy reduces long-term side effects and improves the quality of life for people treated with radiotherapy for throat cancer.

Proton beam therapy is currently only available at two sites across the country, but local people taking part in the trial travel to The Christie NHS Foundation Trust for their treatment.

## New virtual tour of neonatal units

We worked with the Southwest Neonatal Network to create a virtual 360° tour of our special-care baby unit to show parents where their baby will be cared for including the feeding rooms and bedded rooms where they will sleep with their child to prepare for their return home. The tour also gives brothers, sisters, and grandparents a chance to see the unit, as well as including messages from parents whose children have been cared for on our unit.

The neonatal network has created a series of videos highlighting the region's other 11 special-care baby units and neonatal transport service to support parents and answer questions, concerns and worries that they may have in a way that is easy to access, so they can focus on caring for their child.

## Retaining our people

As a people business, we want to ensure we are providing a great place to work so our people stay and thrive. We are working with our NHS partners across Devon to make sure our people are happy, healthy, and have opportunities to develop and grow. Our new retention project provides our people with mentoring opportunities to support healthcare staff to feel empowered, supported and listened to with the aim of supporting them to stay in their roles and in the NHS.

Our emergency department has led the way with this work with nurses and their managers having regular career catchups (also known as stay conversations) to help address reasons why they might want to resign – before they get to that point.

## Horizon Centre redevelopment supports medical student and staff training

Our education and research facility reopened in September after an extensive redevelopment project that will support the training of medical students, multi-professional learners and our people across all our services.

The Horizon Centre is a state-of-the-art environment on the Torbay Hospital site, which hosts many of our education and research initiatives. The works have enhanced the educational and social facilities for both undergraduate learners and the wider staff community.

The redevelopment work cost £660,000 and was funded by the University of Plymouth's Peninsula Medical School. This is in recognition of the increased number of medical students that we now host and will improve their clinical learning and practice experience

## Welcome to our new international doctors

In September we welcomed 18 doctors from Myanmar and India who started their journey to become NHS doctors through the Medical Support Worker programme.

The Medical Support Worker role provides a gateway for international medical graduates and refugee doctors from overseas who come to live and work in England being fast-tracked into the health service and supported to become registered NHS doctors, while working under supervision.

Medical Support Workers already have the experience and training as doctors that, once registered, means they are well placed to apply for training roles in their chosen specialty, more than half of them are now working in a doctor's role for us now having successfully completed the six-month programme.

## Improving access to specialist services through partnerships cross Devon

### Devon's Nightingale hospital's legacy continues to support our people

Having played a significant role providing emergency in-patient care during the first wave of the pandemic, the NHS Nightingale Exeter, hosted by RDUH, is now host to a range of surgical services & diagnostics which are benefiting our patients and communities.

The Nightingale site has been transformed into a state-of-the-art facility and anyone in Torbay and South Devon needing orthopaedic, ophthalmology, diagnostic and rheumatology services can receive care there.

As an asset utilised and resourced by the whole Devon system it is a shining example of collaborative system working; as such hospital also plays a key role in tackling the region's waiting lists and the extra capacity means that our patients can receive their surgery in Exeter sooner than if they received it at Torbay Hospital.

Local people can also receive their CT scan, MRI, x-ray, ultrasound and fluoroscopy diagnostic services at the Nightingale which complement our scanners and help tackle our waiting lists.

## Improving financial value and environmental sustainability

### Our anaesthetists lead the way in reducing carbon emissions

Our anaesthetists have been working hard to reduce the impact that gases that are used during operations can have on the environment.

Anaesthetic gases are commonly used as part of everyday surgeries and are responsible for more than 2% of all NHS emissions. Carbon emissions for one hour of surgery using Desflurane – one of the most common anaesthetic gasses, but also one of the most harmful to the environment - is equivalent to driving 189 miles. Lower carbon alternatives produce the equivalent of four to seven miles.

Our anaesthetists have switched to lower carbon alternatives to minimise their environmental impact. This is not only better for the environment, but also has no impact on patient care, their experience or recovery. We have so far saved 844 tonnes of CO2.

### Creating our health and wellbeing centre

In February, we were delighted to welcome Compass House and Mayfield Medical Centre to Brixham Community Hospital with the opening of their branch surgeries.

With financial support from Brixham Hospital League of Friends, patients of both practices can now access appointments with GPs, phlebotomy, nurses and healthcare assistants at Brixham Hospital.

Great progress was made during the year on the construction of the new Dartmouth Health and Wellbeing Centre.

The centre will give people access to a broad range of health and wellbeing services in one place, by bringing together GPs, community nurses, therapists, the voluntary sector (Dartmouth Caring) and a pharmacy under one roof.

## New £15.7million acute medical unit opens

Our long awaited multi-million-pound acute medical unit (AMU) opened its doors in December.

Our AMU is split over two levels and has 36 assessment spaces where patients who have either been referred from our emergency department, from GPs, the community and other specialities can receive a wide range of high-quality care.

The unit is located alongside the emergency department and having the two units side-by-side is already improving the flow of patients across the two departments, allowing for more timely patient reviews and a better patient experience.

Torbay Hospital's League of Friends generously donated more than £500,000 to the project with the funds helping to equip the AMU with new patient trolleys and recliners.

The AMU is the flagship of our building a brighter future programme which aims to make a real difference to how we deliver services with, to, and for our people.

## Funding secured for additional theatres and improvements to endoscopy services at Torbay Hospital

An extra 4,500 people a year needing hip, knee and eye operations will be able to receive their operations at Torbay Hospital thanks to a £15million capital investment to improve services and reduce waiting lists.

The funding is being used to create two modular theatres and additional pre-operative assessment and recovery spaces. The extra theatre capacity will help reduce the length of time local people have to wait for day surgery, and also improve the quality and experience of care.

Meanwhile a £4.99million capital investment has been secured to modernise and increase our Endoscopy facilities.  The old building has been demolished and the new modular facility will create a fourth endoscopy room and a larger training facility which will help increase the numbers of people who can be seen, reducing waiting times and improving experiences and outcomes. Both new developments are due to be completed next year.

## PERFORMANCE ANALYSIS

### Financial position

The financial framework in 2022/23 no longer contained the majority of the income 'top-up' processes that were introduced by NHS England in the financial year 2020/21 and which continued into 2021/22 for the actions needed to respond to the COVID-19 epidemic.

Our financial plan for 2022/23, excluding the net cost of donated income, expenditure and the impact of the year end Buildings and Land revaluation, was to produce a small revenue surplus of £69,000. Delivering this plan required us to produce savings of circa £28.5m and also required us to minimise the impact of inflation on the cost of goods and supplies that we purchase from third parties.

Actual savings delivered during 2022/23 totaled £25.0m, but cost pressures have been substantial and consequently we ended the year with a deficit of circa £17.1m (excluding the net cost of donated income, expenditure and the impact of the revaluation of Buildings and Land).

Inclusive of the net impact of Donated income and expenditure transactions as well as impairments caused through the revaluation of Land and Buildings, our total revenue deficit for the year totaled circa £24.3m as set out in Financial Statements.

Our financial environment for 2023/24 remains challenging. Renewed focus will be required to contain cost pressures and to also to deliver a substantial savings programme of circa £46.6m. After delivery of those savings a planned revenue deficit of £32.6m will be delivered. We will be required to reduce this planned deficit in 2023/24 in subsequent years through further savings programmes.

#### Going concern

Our financial statements have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires the Board to assess, as part of the account's preparation process, our organisation's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the trust without transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

### Operational performance

A summary of the key clinical access performance standards used by regulators to assess our performance is set out below for 2023/24 and further analysis can be reviewed within the performance section of the report (page number to be added).

## Urgent and emergency care performance

Along with the wider Devon system, we have been under review from NHS England national and regional teams in relation to ambulance handover performance throughout 2022/23. Moving into 2023/24 we have plans to eliminate handover delays above 15 minutes by the end of March 2024. This improvement in performance will simultaneously contribute to the Devon system position as the Devon system has been placed in Tier 1 monitoring for ambulance handovers.

In relation to the national four-hour standard we have a performance trajectory agreed with regulators that moves us to a position of 76% achievement by the end of March 2024.

We have has made progress against both the ambulance handover delays and four-hour performance in quarter 4 of 2022/23 but will need to consistently sustain improvement throughout the year. In order to provide assurance and progress an Urgent and Emergency Care Board has been established focusing on three key workstream to drive the improvement: emergency department clinical pathways, same day emergency care and flow and ward improvement.

Reducing the number of patients who are medically fit to go home (what we call people with ‘no criteria to reside’) to 5% of the bed base is a further target for next year. We consistently achieved the best performance across Devon during 2022/23 and regularly achieved days of between 5-8% performance. Maintaining and building on this performance as an integrated care organisation will be key to supporting an improvement in ambulance handover delays and the four-hour standards and as such the target is actively monitored in our Urgent and Emergency Care Board.

In January, part of our Torbay adult social care services, the Technology Enabled Care Service (TECS), launched a new initiative to help with flow through Torbay Hospital. The pilot ran in the discharge lounge and across two wards. People who were waiting in hospital for a care package were shown how to use the technological aids on offer and given a six week trial of the equipment. In its first month, this trial saw 19 hospital bed days saved, a reduction in discharge delays and with all but one patient, a likelihood of a reduction of calls to primary or emergency services. The service is free to the client and is not dependent on meeting eligibility criteria, only that the referrer at the point of discharge decides that having the equipment could reduce discharge delays, reduce the number of days spent in hospital, or reduce the number of calls to the patient’s GP, 111, or 999. The trial ran for six months until the end of July and will be widened to include the short-term services such as rapid response and reablement teams.

## Elective performance

Our achievements and planning during the period 2022/23 will influence local health and care landscape for many years to come. During the past year we have been under scrutiny by NHS England national and regional teams. During the year we were placed in Tier 1 monitoring for cancer and routine care, requiring the highest levels of scrutiny and oversight.

Since year end, we have delivered material improvements in our cancer and planned care pathways and have met the threshold in cancer to be downgraded from Tier 1 to Tier 2, improving on the efficiencies derived during 2022/23. At the same time, we were the only Devon acute provider to achieve the target of no one waiting more than 104 weeks to begin treatment by the end of March 2023. These achievements alongside our plans to expand our theatre and diagnostic capacities in 2023/24 are key to us delivering better health and care for all in line with our organisational vision.

## Quality Goals

Our understanding of quality reflects the description of quality as set out in the '*High Quality for All, NHS Next Stage Review' (2008).* The three components of quality; safety, effectiveness and patient experience are linked. A service cannot be judged to be excellent because it is safe while ignoring its effectiveness or people's experience.

We held a number of listening and engagement sessions with our people between February and June 2021 to help us identify our key issues and explore the options to address them. Together we co-designed our four quality and safety goals for 2022/23 which are aligned to our vision for better health and care for all.

In the Quality Account for 2022/23, we share our progress against the clinical improvement priorities we agreed against the four quality goals, specifically:

- ✓ sepsis
- ✓ deteriorating patient
- ✓ falls
- ✓ nutrition and hydration
- ✓ experience of patients on discharge.

Supporting our approach to moderinising our approach to quality, our digital transformation team has worked tirelessly on the development of the outline business case for an Electronic Patient Record (EPR), which was approved by our Board of Directors in March 2023. We are one of the priority trusts set to receive funding from the National Frontline Digitisation Programme and this investment will be a critical part of the transformation of our services.

Our services across Devon remain challenged and over the last year there has been a real focus on improvement by working in partnership with local health and care providers. We have collaborative arrangements in place to improve the way we deliver our acute care and community services.

Our commitment to Building a Brighter Future for our patients, staff and local communities is outlined within our strategy and there has been a significant amount of progress made to attract investment to improve our infrastructure. Our virtual ward investment means that we can care for more patients who require specialist oversight in their own homes. Alongside this we have secured additional investment in day surgery and endoscopy facilities. Our strategic outline case for investment from the New Hospital Programme has been submitted to the national team and we are preparing our site enabling plans.

Our communications and engagement team are now working within their new structure and delivering on our commitment to meaningful conversations, which are aligned with our plan to improve our services aligned with our compassionate leadership approach. This engagement aims to ensure that our improvement ambitions are owned by all members of our team and we each feel empowered to make a difference to the people we serve.

### COVID-19 and flu immunisation programme

In September 2022 we launched our joint COVID -19 and flu immunisation programme for all our people directly employed on trust contracts. More than 65% of our people took up the offer of vaccination.

### Transformation and partnerships

During the year we made considerable progress in developing our capacity and capability to innovate and improve by investing in our central team and creating a culture of improvement through a comprehensive coaching programme. Our improvement and innovation team provide expertise and support for key goals and priorities within our strategy including:

- our quality goals (see below) and the delivery of our four quality pillars
- performance improvement for emergency, elective, cancer and community services
- improving our financial efficiency
- transforming services for our future.

### Our people

There has been an increased focus on transforming how our workforce is rostered, utilising e-rostering, enabling us insights into hours worked and the efficient use of bank and agency workers where need arises. This has enabled us to further embrace digital transformation to analyse our workforce expenditure and management.

Monthly analysis is performed on our workforce information to ensure that we are manging absences, vacancies, and training. Whilst we have remained in normal tolerance levels throughout the year, absence due to sickness did noticeably increase during the winter months and therefore the use of agency workers to maintain safe staffing levels did increase.

The protection of staff and patients was a major concern during the COVID-19 pandemic. We have continued to follow national and local guidance in our response to the virus as well as continue to ensure availability of medically fit staff to provide care for our patients and the NHS nationally. This has been significantly challenging so there remains a continued focus on ensuring we actively support the health and wellbeing of our people including their emotional wellbeing, while ensuring we are able to move people to support clinical areas where needed.

## FURTHER PERFORMANCE ANALYSIS

### National standards

This performance overview provides information about how we have performed against agreed operational objectives during the year.

2022/23 has been a challenging year for the Trust with ongoing recovery from the COVID-19 pandemic. Workforce and estates capacity, along with other factors, resulted in a lower level of clinical activity than planned which impacted on elective performance and saw waiting lists climb. Across Urgent and Emergency Care performance patient flow was the main operational challenge resulting in increased length of stay and frequently full to capacity in the Emergency department and assessment units. The 4-hour standard and ambulance handover delays did not meet planned levels of performance.

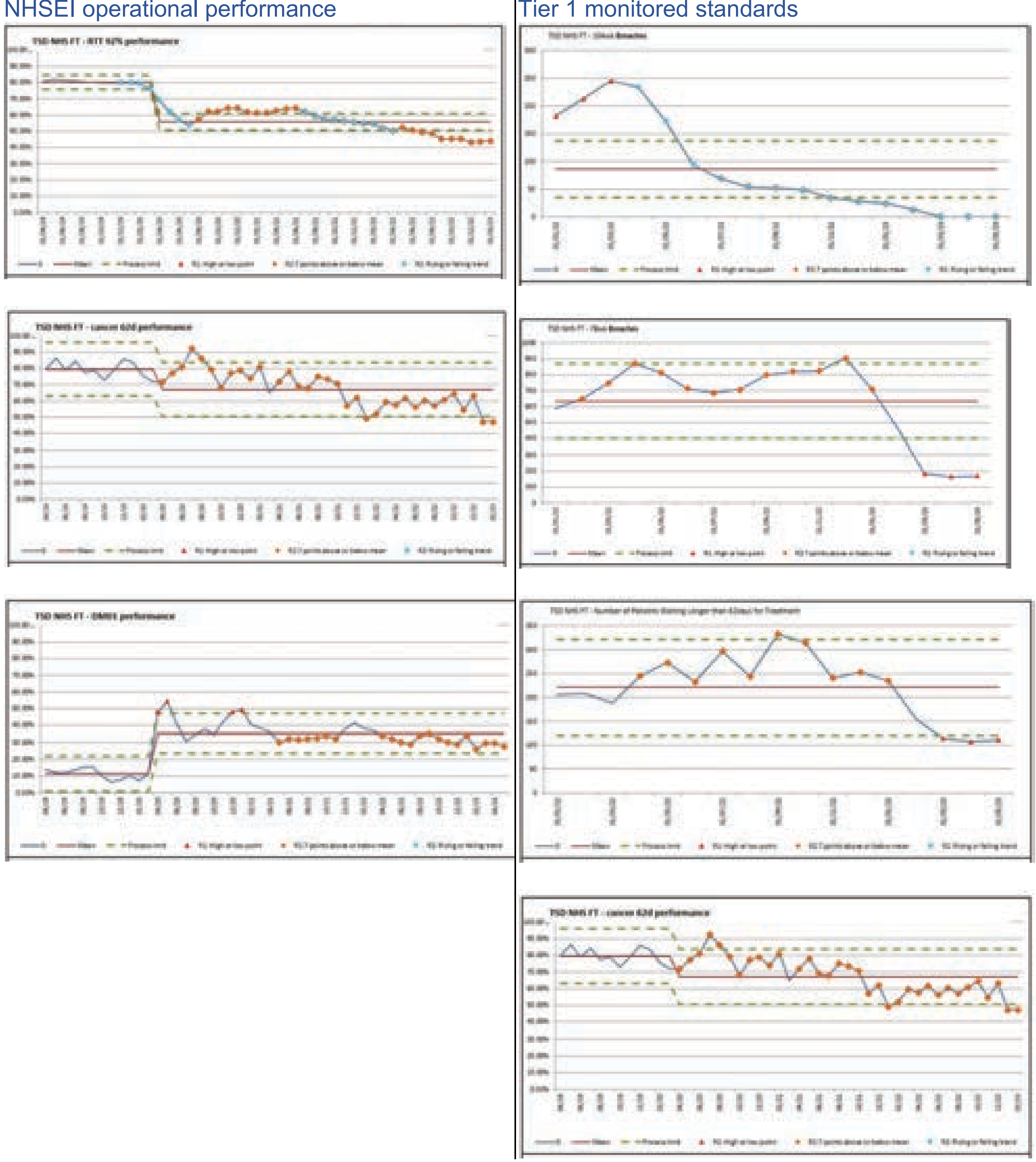
The Trust, along with other providers in Devon, has experienced long patient waits for Referral to Treatment and cancer care. Since June 2022, the Trust has been required to comply with Tier 1 performance reporting, Tier 1 being the highest level of regulatory performance oversight.

The two areas of Tier 1 performance requiring improvement are against Referral to Treatment long waits over 104 and 78 weeks, and against the number of patients waiting over 62 days for treatment following an urgent cancer referral.

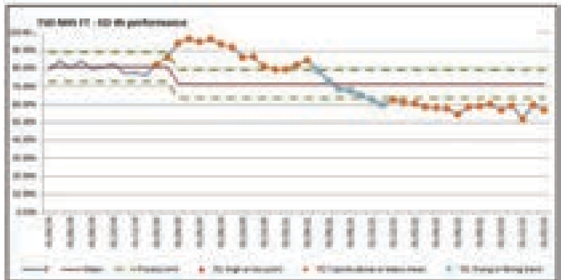
Tier 1 oversight required weekly meetings with the Trust's Chief Operating Officer and the South West Region Performance Director to review progress against plans. At the end of March 2023, the Trust had achieved the clearance of all 104-week waiting patients, delivered a total of 183 against the agreed trajectory of 176 for reduction of 78-week waiting patients, and achieved the cancer 62-day pathway backlog reduction leading to the achievement of the Tier 1 exit criteria.

During the reporting period, performance reports were provided monthly to the Finance, Performance, and Digital Committee, and to the Trust Board of Directors. These reports covered all the Tier 1 and other operational plan performance standards.

The key performance indicators for 2022/23 are shown in the analysis below, some of the introductory supporting charts shown on page x, overleaf:


NHSEI operational performance
Tier 1 monitored standards

## Four-hour Emergency Department (ED) waiting times & "No Criteria to Reside"



Performance against the 4-hour standard in the Emergency Department in 2022/23 has continued to reflect the challenges of capacity and managing daily patient flow. Long waits have continued to be experienced in the emergency department. Ambulance handover delays have also been high due to the department being full at times. Managing Covid-19 and designating ward beds to meet infection control safeguards have had a sustained on hospital capacity. Quarter 4 has seen a series of industrial actions from a Junior Doctors, Nurses and Therapists that has impacted on performance. The Trust developed a robust process to manage these to ensure patient safety.

Bed capacity has been increased by the opening of the new Acute Medical Unit (AMU) in December 2022 and the discharge lounge has been expanded.

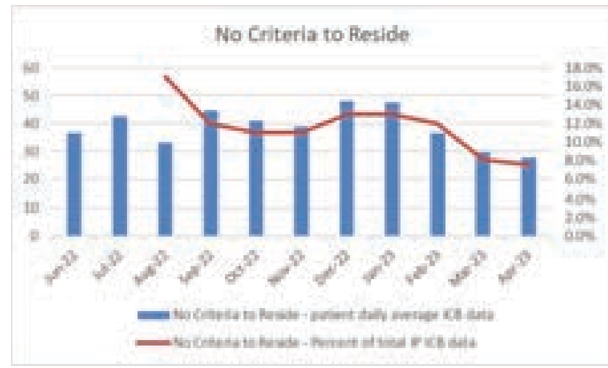
The Trust's improvement actions have focused on increasing the number of daily discharges earlier in the day and at weekends along with reducing the number of patients in hospital with "No Criteria To Reside" (further detail below). Progress has been seen with improved planning and daily escalation. The number of patients with no criteria to reside has reduced from a daily average of 48 (13%) in December 2022 to 28 (8%) March 2023. Ambulance handover delays have improved in Quarter 4 (Q4 month average of 789 over 30-minute delays compared to 1140 in Q3), however, remain a challenge with further improvement required in 2023/24.

- The Plan for 2023/24 is to meet the new national 76% operating plan target against the 4-hour performance by March 2024. There are a number of further developments supported by the Urgent and Emergency Care transformation programme to increase effective bed capacity for emergency admissions, patient flow, and pathways within the emergency department. These plans include the introduction of virtual ward pathways of care to facilitate earlier discharge and reduce admissions to improve demand for beds;
- support for the complex discharge process and the capacity of intermediate and social care to reduce further the number of 'No Criteria To Reside' to 5%;
- continued focus on timeliness of daily discharges, use of the discharge lounge, and increased number of weekend discharges;
- optimisation of clinical pathways to the new Acute Medical Unit to increase the number of Same Day Emergency Care discharges;
- focus on reducing breaches of the 4-hour standard for non-admitted pathways of care.
- streaming patients to alternatives to ED such as Urgent Treatment Centres, pharmacies and self-care.

### Further information on "No Criteria to Reside"

As noted above, this is the status of a patient who (having undergone appropriate treatment and assessment) no longer meets the medical criteria to stay in an acute or community hospital bed; previously known as a delayed discharge.

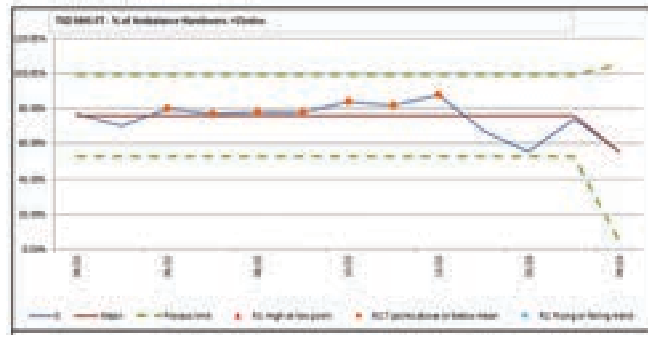
A patient occupying a hospital bed with No Criteria To Reside is potentially occupying a bed space needed for patients requiring admission from the Emergency department, Assessment units or transfer into a Community Hospital. This has contributed to delays in the Emergency department and ambulance handover delays as full capacity is reached. For these reasons the Trust has implemented an improvement programme (outlined above) supported with funding to remove any process delays in discharge and increase capacity, particularly for the more complex discharges where other care packages or intermediate care support is needed.




During the year the number of beds occupied in the acute and community hospitals with No Criteria To Reside has improved from over 13% of beds occupied to 8% in March and 7.5% in April 2023. The recovery target set for improvement for No Criteria To Reside is 5% for 2023/24.

Within our Urgent & Emergency Care performance analysis above, we detail how we have utilised our position as an integrated care organisation to support the associated improvement plans and supported a pilot run by the Technology Enabled Care Service (TECS), page x.

### Ambulance handovers



Ambulance Handover delays were challenging for 2022/2023 particularly in Quarters 1-3 with 70-88% of all arrivals in excess of the 15-minute handover standard. Quarter 4 saw the opening of the Acute Medical Unit and provided support to patient flow in the hospital. During the same Quarter the Trust placed a key focus on committing to improving the two main causes of patient flow imbalance by improving performance by increasing the number of patient discharges before noon and increasing the number of weekend discharges.

As a result of the above the Trust saw a benefit to flow within the hospital and emergency department and as result a positive reduction in handover delays to 55% over 15 minutes in April 2023.

The plan for 2023/34 to continue to build on the improvements above and through the Urgent and Emergency Care Board work towards no ambulance delays at the end of March 2024.

### Referral to treatment (RTT) access times

The number of patients waiting for treatment increased during the year with 40,180 patients waiting at the end of March 2023 for first definitive treatment, up from 37,261 at the start of the year. The number of patients waiting over 104 weeks, however, has been reduced to zero in this time and the Trust achieved its Tier 1 improvement trajectory to reduce the number of patients waiting over 78 weeks.

The Day Surgery Unit is a national exemplar in day case surgery completion rates and productivity. During covid escalation the Day Surgery Unit was used periodically as covid escalation for emergency admission assessment with a consequential increase of day surgery waiting lists. In April 2022, following the completion of the interim medical assessment areas the Day Surgery unit was fully restored to elective use. This has enabled teams to increase the number of day case procedures undertaken and start to reduce the number of patients waiting for day case procedures.

In 2022/23 the Trust worked closely with system partners to make use of allocated capacity at the former Nightingale Hospital in Exeter recommissioned to provide elective Orthopaedic short stay procedures and diagnostic hub. In 2023/24 this allocation of capacity has been increased with cataract procedures also now commenced.

In the outpatient setting of care, challenges have been seen with increases in waiting times for outpatient appointments and outpatient treatments. Through a focus on outpatient productivity, including pathways to utilise virtual non-face to face appointments and managing follow up pathways to release capacity, performance has started to improve. Work continues to support patient capacity and productivity through the outpatient service transformation programme and insourcing of additional clinical capacity in the most challenged areas.

The plans for 2023/24 are to have no patient waiting over 65 weeks. These plans are reliant on recruitment to vacant posts, sourcing of additional capacity and system mutual aid. The Trust has successfully bid to increase day surgery and endoscopy theatre capacity with two additional day surgery theatres and an additional endoscopy suite scheduled for completion in Quarter 4 2023/24.

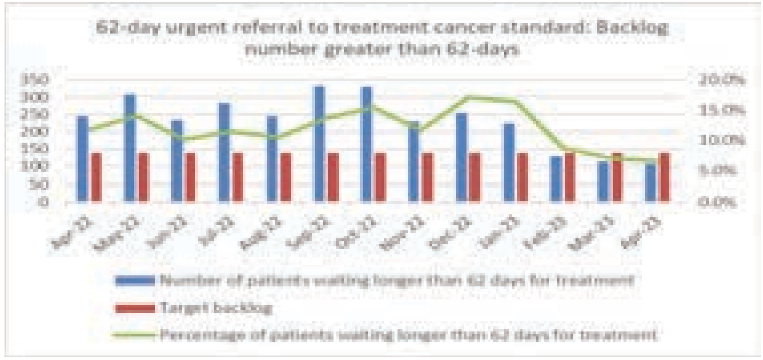
### Referral to Treatment - 65 week wait Tier 1 monitoring and trajectory

### Cancer standards

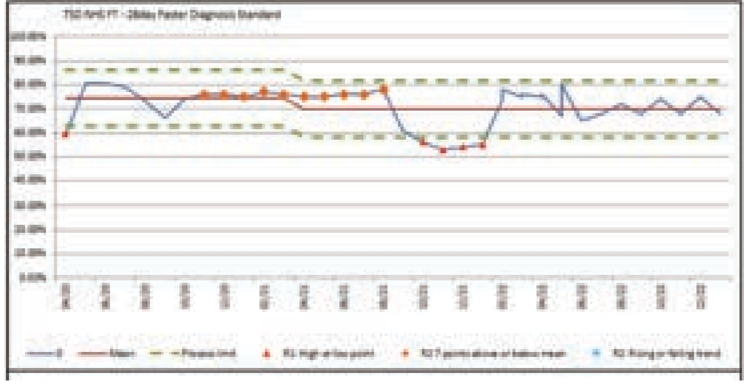
The Trust maintained its commitment to prioritise delivery of cancer treatments. The Trust, however, entered Tier 1 performance monitoring by NHSE due to the increasing number of patients waiting beyond 62 days for treatment following urgent referral. Since November 2022 there has been steady improvement with the backlog reduction meeting the threshold for stepping down out of Tier 1. This number reduced from 333 patients in November 2022 (13.6% of total list) to 114 patients (7% of total list) by end of March 2023.

Over the year the Trust has not consistently met the 14-day urgent referral to be seen, nor 28-day from urgent referral to diagnosis standards. There are known challenges and risks. However, close monitoring is in place with action plans reviewed through cancer performance oversight. In March 2023 the Trust achieved 77.4% against the 28-day referral to diagnosis standard (target 75%) and 76% against the 2ww standard (target 93%).

### Over 62-day referral to treatment standard: greater than 62-day backlog (open pathways)




### Faster diagnosis 28-days from referral cancer standard



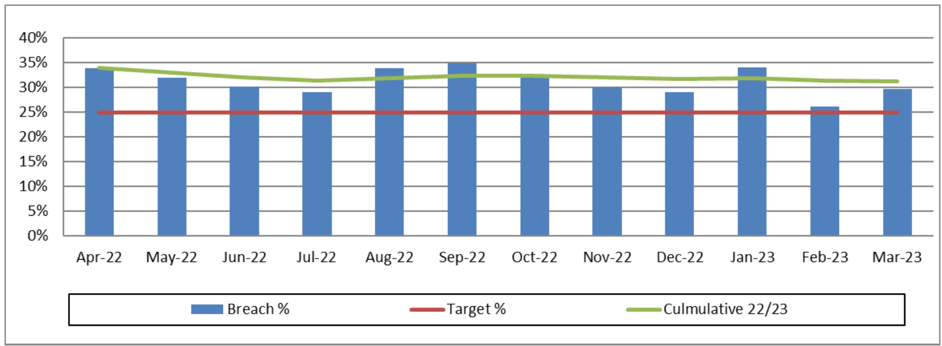
## Diagnostics

Diagnostics: Demand for diagnostic tests has continued to increase. The delivery of required levels of capacity in CT and MRI is dependent upon the sourcing of additional capacity using mobile units. The Trust will commission a new Radiotherapy Planning CT scanner at Torbay which will be operational by September 2023 and will strengthen our Clinical Oncology pathways. The Nightingale Hospital Exeter has continued to support Torbay by offering additional CT and MRI capacity.

Recruiting to staff vacancies across the major diagnostic specialties remained a challenge throughout the year.

Endoscopy services has used additionally sourced weekend capacity throughout the year to stabilise waiting lists along with additional mobile capacity to support waiting list initiatives in preparation to the estates works to create additional facilities that will impact for a period in 2024/25.

### Diagnostic greater than six-week wait breaches as a percentage of total waits




## Equality of service delivery

The Trust maintains its approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting patients by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact with patients is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should a patient's condition change or they fail to engage with offered appointments.

The Devon System is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital Exeter as a system resource to support additional capacity for diagnostics, orthopaedic, and ophthalmology treatments.

Assurance and performance monitoring: Weekly assurance meetings are held with operational leads and the System Care Group Directors reporting to the Chief Operating Officer.

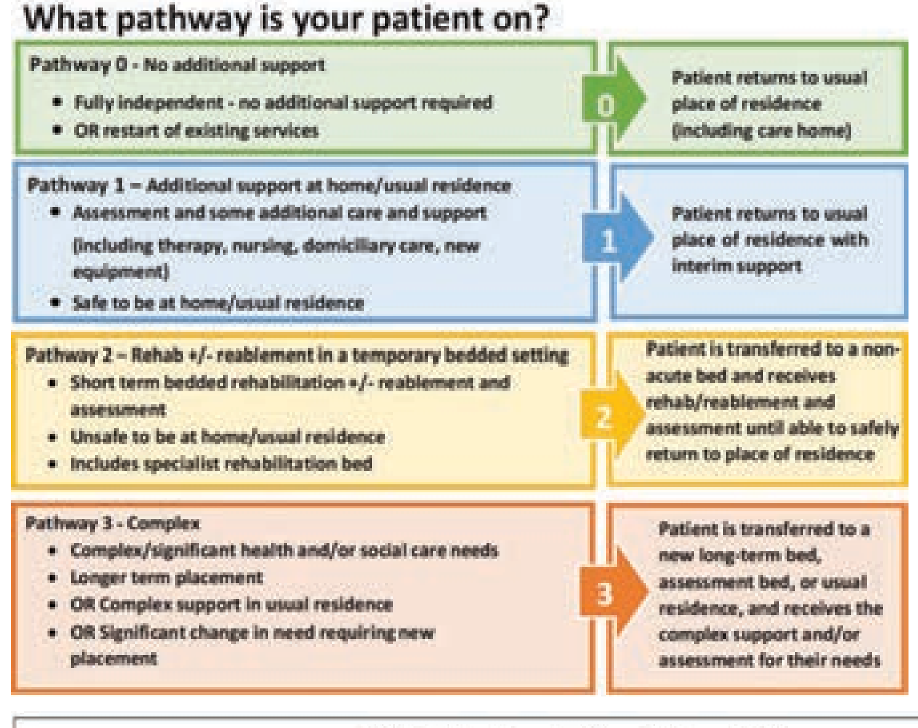
These meetings are in addition to the monthly Integrated Service Unit (ISU), executive-led, Integrated Governance Group (IGG) Meetings where performance is reviewed with system leadership teams following each ISU's monthly governance process.

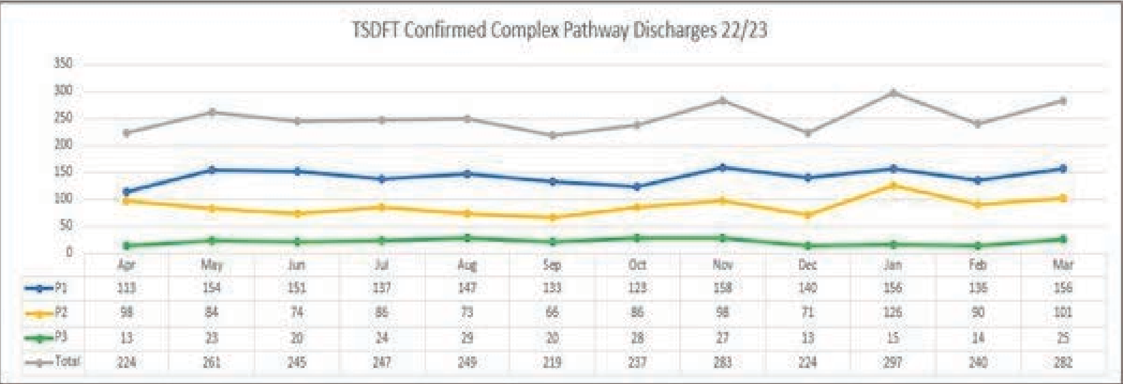
In 2023/24, monthly Urgent Care and Planned Care Board meetings are now established to track the delivery of transformation programme and performance against agreed plans.

This process gives the Executive Team and Board of Directors assurance in relation to performance monitoring, escalation of performance risks where additional support is needed, and actions being taken.

## Other areas of Performance to note

### Complex Pathway Discharges




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P1 | 113 | 154 | 151 | 137 | 147 | 133 | 123 | 158 | 140 | 156 | 136 | 156 |
| P2 | 98 | 84 | 74 | 86 | 73 | 66 | 86 | 98 | 71 | 126 | 90 | 101 |
| P3 | 13 | 23 | 20 | 24 | 29 | 20 | 28 | 27 | 13 | 15 | 14 | 25 |
| Total | 224 | 261 | 245 | 247 | 249 | 219 | 237 | 283 | 224 | 297 | 240 | 282 |

The total number of patients discharged through pathways 1-3 has remained fairly consistent throughout most of the year, averaging 251 complex pathway discharges per month. Pathways 1-3 are considered ‘complex’ as patients require support to enable a safe discharge.

During December the number of pathway 2 patients discharged decreased. There was also an increase of Covid cases which led to ward closures and care homes adhering to the guidelines for admission.

Throughout early January, providers began to accept new referrals again, and additional block contracted beds were purchased to support discharge into temporary bedded placement. This resulted in a year high for Pathway 2 discharges, and a total of 297 complex pathway discharges for January.

Across the 12 months the following numbers of patients were discharged on each pathway

| Pathway | % | Actual |
|---|---|---|
| 1 | 56.65 | **1704** |
| 2 | 35.01 | **1053** |
| 3 | 8.34 | **251** |

## Average Length of Stay

The average length of stay in 2022/23 has increased however this remains in line with other South West Provider Trusts. In 2022/23 the average length of stay for patients admitted as an emergency and staying overnight was 7.9 days and this compares to 7.6 days average across other South West provider Trusts. Infection issues, specifically Covid, have contributed to this increase length of stay. Moving into 2023/24 reducing length of stay remains an ongoing key focus for the Trust to support both elective and non-elective activity and as such has been recognised in improvement plans specifically centered on early morning discharge, discharges before 5pm and at the weekend.

## Stroke care

Patients presenting with suspected Stroke require rapid assessment diagnostics and dedicated rehabilitation care. The Sentinel Stroke National Audit Programme (SSNAP) measures the time critical processes of care provided across acute and community settings. The Trust did not meet the standards for the percentage of patients admitted to a stroke unit within 4-hours of arrival or the percentage of patients spending 90% or more of their hospital stay on a dedicated stroke ward. The Trust has a Stroke Improvement Plan to support patient outcomes and achievement of time critical standards. This plan is managed through the clinically led Stroke Governance meeting.

## Winter planning 2022/23

The Trust improved its operational resilience heading into winter with an understanding that Covid and general winter pressures would be challenging and there would be an ongoing need to clinically risk management patients and importantly support the ongoing work to improve ambulance handovers and response times.

In conjunction with Devon system wide partners the Trust focused on the following key themes of improvement:

- Establishing a Winter Control Room to support daily operational challenges
- Better support for people in the community
- Delivering on our ambitions to maximise bed capacity and support ambulance services
- Ensure timely discharge and support people to leave hospital when clinically appropriate

Key areas of support that helped maintain the resilience during the winter period were the continuation of 11 Emergency Department Escalation beds, the expansion of the discharge lounge, opening of the new Acute Medical Unit and maintaining McCullum ward for winter escalation. Community support in the form of additional Care Home placements and packages of care likewise contributed to resilience.

## Maternity Performance 2022/23:

Maternity assurance metrics are based on recommendations to meet the national priorities to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025.They are also based on the requirements set out in the Maternity Incentive Scheme (MIS) as part of the Clinical Negligence Scheme for the Trust (CNST) as well as those recommendations from both the Ockenden and East Kent Hospitals reports.

A monthly dashboard is produced which is monitored via maternity governance group. Metrics are shared via quality assurance groups within the organisation. An integrated performance report is shared at the monthly Trust Board meetings.

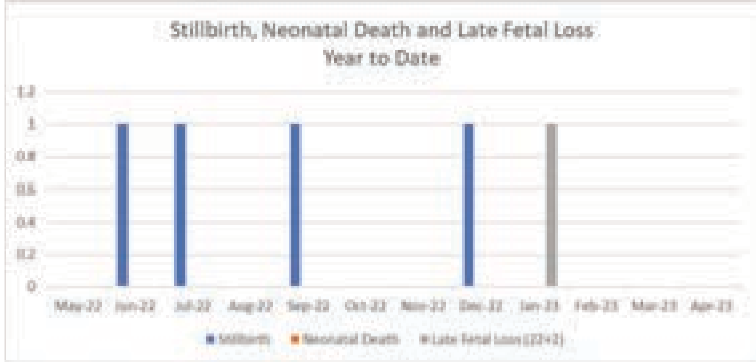
### Birth rate

The number of births for 22/23 was 1,847. This is a reduction from 21/22 when it was 2,073. Reduction in birth rate is a national trend.

### Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 22/23 – there were 5 deaths.

Torbay’s perinatal mortality rate for 2022 is 4.2% which is the same as the national average. A deep dive/thematic review was carried out into all deaths in 2022 and no themes or issues with care were identified.




### Smoking rates

There has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically the SATOD data was 13-15%. With the introduction of the Smoke-free Pregnancy team this rate has dropped to 7.3% for the year 2022/23. This is below the national average of 8.6%.

### Identifying fetal growth restriction

Data on our detection of small for gestational age (SGA) babies in Quarter 4 of 22/23 has evidenced performance above the recommended average. Torbay is one of the Top 10 Trusts in the country for detection of small babies. The Trust has achieved a detection rate of 69.2% which is significantly higher than the National average of 43.6%.

## Financial Performance

### Funding overview

We earned over £644 million of income during 2022/23, primarily from clinical activities, but also received a significant contribution from education and training and other income generation activities.

In 2022/23 the majority of our clinical income and adult social care income was received through block contract income streams received via NHS Devon Integrated Care Board and Torbay Council respectively.

The funding arrangements for the 2023/24 financial year continue to be mostly block contract related, but reduced financial support is now in place for our response to COVID-19. Greater financial emphasis is also being placed on earned elective recovery income to reduce waiting lists on planned care pathways.

Excluding the cost of pay awards to staff, which are funded centrally, planned income is forecast to reduce by circa £5m in 2023/24. This coupled with recurrent savings shortfalls brought forward from 2022/23 totaling circa £15m, further forecast significant inflationary cost pressures on consumables and care services provided by the Independent (out of hospital) Sector, we are forecasting a deficit of £32.6m during 2023/24, after an in year 2023/24 planned savings target of £46.6m. During this period of time, interim support in the form of Public Dividend Capital (PDC) from the Department of Health and Social Care (DHSC) will be accessed to ensure that adequate financial support is in place throughout 2023/24.

### Value for Money

To help demonstrate value for money, we use benchmarking information such as the NHS productivity metrics. For procurement of non-pay related items, we have a procurement strategy which maximises value using national contracts and through collaboration with other NHS bodies in the Peninsula Purchasing and Supply Alliance.

Under the National Audit Office ('NAO') Code for 2022/23, our external auditor, Grant Thornton LLP, will issue an Auditor's Annual Report providing a commentary on the Trust's arrangements to secure Value for Money. – Outcome to be added into the Final Annual Report version.

### Capital developments during the last year

During 2022/23 we continued to invest in our facilities and equipment and carried out capital projects including recognition of in-year Right of Use Assets additions totaling £45.9 million. In addition to this sum, we received charitable donations totaling £1.7 million. Part of our capital expenditure has been supported by the Public Dividend Capital received from the Department of Health and Social Care and through other sources of financing such as leases with both commercial providers and public sector organisations.

### Cashflow

Our cash position has decreased, from a starting point at 01 April 2022 of £39.3m, to a sum of £34.7m, as at 31 March 2023. The reduction in cash balance has primarily been primarily driven by movements in our working capital, most notably an increase in Inventories totaling £2.1m.

Other liabilities and Trade and other payables - creditors totaling circa £20.0m will unwind over the first part of the financial year 2023/24 as suppliers' invoices become due for payment and as deferred income performance obligations are met.

During 2023/24, we will continue to maintain detailed cashflow forecasts to assist with cash planning. We will request financial support from arrangements that are proven and already in place with the Department of Health and Social Care to ensure that we continue to meet our contractual obligations to suppliers, staff and other government agencies.

### Financial framework

Being licensed as an NHS Foundation Trust means that we are more accountable to its local public and patients. With effect from 01 April 2016, Monitor became part of NHS England / Improvement. Since that date the financial framework of NHS Foundation Trusts and NHS (non Foundation) Trusts have become more aligned.

As noted in Part II of the annual report, our financial performance continues to be monitored by NHS England

### Accounting framework

As an NHS Foundation Trust, we apply accounting policies compliant with the Department of Health and Social Care's Group Accounting Manual (GAM). The DHSC GAM includes mandatory accounting guidance for DHSC group bodies completing statutory annual reports and accounts. These group bodies include clinical commissioning groups, NHS trusts, NHS foundation trusts and arm's length bodies.

The GAM is approved by the HM Treasury Financial Reporting Advisory Board.

### Accounting policies

Accounting policies for pensions and other retirement benefits are set out in a note to the full accounts (note 1.8) and details of senior employees' remuneration are given in the Remuneration Report.

## Charitable funds

Torbay and South Devon NHS Charitable Fund is a registered charity (number 1052232) and as such a separate legal entity, established to hold charitable donations given to Torbay and South Devon NHS Foundation Trust. Donations are received from individuals and organisations and are independent of the monies provided by the government.

Based upon the most up to date figures (subject to audit), in 2022/23 the Charitable Fund received donations and legacies totalling £2,339,000.

Included within this figure were extremely generous donations from the Torbay Hospital League of Friends (£1,570k, including funding for equipment for the new Acute Medical Unit and CT scanners) and Brixham Hospital League of Friends (£309k). The Charitable Fund also received £163,000 from Torbay Medical Research Fund in respect of various research projects.

We continue to complete projects funded by grants from NHS Charities Together, the organisation which distributed donations given to the NHS in response to the COVID-19 pandemic.

Other donations have been used to purchase numerous items of medical and other equipment, as well as supporting the training and development of staff and patient/client welfare. Full details can be found in our Charitable Fund Annual Report and Accounts, which we produce in our role as corporate trustee.

## Emergency Preparedness, Resilience and Response (EPRR)

### NHS England EPRR Assurance

On 30 November 2022, our Board of Directors received and approved the outcome of the NHS England / Integrated Care Board EPRR core standards assessment for 2021 in relation to our responsibilities as a category 1 responder under the Civil Contingencies Act (2004). Assurance was provided to our Board that against the 64 standards we scored: 60 fully compliant standards and four partially compliant standards moving us to an overall rating of substantially compliant from partially compliant following the previous year, demonstrating a significant improvement.

During the year we implemented our incident response plan and began rolling out a training programme across the organisation to staff who are involved in such situations.

In addition to the core standards assessment, we participated in an external audit from South Western Ambulance Service NHS Foundation Trust in relation to the Chemical, Biological, Radiological and Nuclear (CBRN) capability audit. We successfully passed the audit with no further recommendations, evidencing the process in place to manage a CBRN incident.

### EPRR Incidents 2022/23:

During the year, we recorded six business continuity incidents through our Datix system. We had no confirmed major incidents. We are unable to report on critical incidents as the reporting mechanism was partway through the financial year.

The business continuity incidents related to:

- a failure of water pump, preventing a loss of facilities
- a cyber-attack occurred on a contractor that supplies our catering supplies
- red warning for extreme heat
- water leak in a patient facing area
- power outage in theatres and the main entrance corridors.

'Hot' debriefs were completed and lesson have been identified and added to our lessons identified tracker.

### EPRR risk register

The EPRR risk register is being reviewed to assist in mitigating organisational and community risk. This review of the risk register then will aid the work plan for the EPRR team for 2023/24.

### EPRR training and exercising

During the year the EPRR team delivered the following training courses:

| Course name | Number of roles completed course | Number of roles required to complete the course (KPI) | Rating In performance |
|---|---|---|---|
| Loggist training | 17 | 32 | Less than 75% |
| Tactical command | 34 | 62 | Less than 75% |
| Strategic command | 4 | 14 | Less than 50% |
| Decontamination recertification | 9 | 32 | Less than 50% |
| Total | 58 | 140 | Less than 50% |

As a result of OPEL 4, industrial action and critical incidents, significant training was cancelled over the course of the year. The priority for 2023/24 will be to deliver more than 75% training to people in key roles across the organisation.

During the year we took part in two main exercises. ‘Exercise Drogon’ on 01 September 2022 tested NHS Devon’s system critical incident plan. On 09 March 2023 we were involved in a test of the mass casualty distribution plan with South Western Ambulance Service NHS Foundation Trust. The debrief reports will be shared for lessons to be learnt and adopted.

### Environmental matters and the impact on the environment

We recognise that climate change and carbon emissions present a risk to health at both the national and global level. As a provider of healthcare and as a publicly-funded organisation, we are committed to ensuring the long-term sustainability of the natural environment and a contribution to the reduction of carbon emissions, in order to deliver sustainable healthcare and to safeguard human health.

- In 2020, NHS England defined two clear targets, which we are aligned to:for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (the NHS Carbon Footprint Plus)), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Our green plan was formally approved at our Board of Directors meeting in February 2022 and forms part of our broader Integrated Care System green plan for Devon and is also a key enabling plan for our organisational strategy and vision of better health and care for all.

Our green plan defines our commitment to environmental sustainability with a primary focus on how we will drive towards the NHS net zero targets. The key outcomes include:

- ensuring we are aligned to the NHS-wide ambition, and that of the Integrated Care System for Devon to become the world’s first healthcare system to reach net zero carbon emission
- prioritising interventions which improve the quality of healthcare we deliver, while also tackling greenhouse gas emissions and broader sustainability challenges
- defining our strategic approach in such a way that we make the right sustainability decisions first time.

A further update on progress against our green plan was presented to our Board of Directors in February 2023 and confirmed that good progress has been made against the majority of the actions and commitments we have made, along with our commitment to decarbonisation, sustainable development and achievement of national objectives, continue to be key priorities for us.

Through our green plan, we are focusing on the following areas to achieve net zero carbon:

- how we manage our existing buildings in the context of energy use and decarbonisation
- how we build new buildings that are net zero carbon in their construction and operation
- how we manage our consumption of water
- how we manage our waste streams
- how we support and develop sustainable travel and transport for patients, staff and visitors, encouraging sustainable travel modes where appropriate
- how we manage the reduction of our carbon footprint relating to anaesthetic gases and other pharmaceutical products
- how we innovate to provide net zero carbon healthcare embracing new working practices and digital enablers
- how we work with our supply chain to reduce, minimise and eventually decarbonise
- how we encourage and develop biodiversity across our green spaces for the benefit of patients, staff and visitors
- how we adapt to ensure we meet the challenges that will arise from climate change.

Our achievements this year include:

- the implementation and review of our green travel plan, which was underpinned by several initiatives, including a phased implementation of virtual ward models for frailty and respiratory services, and the launch of a full review into the management of staff parking, with a view to improving uptake in more environmentally-friendly transport and travel methods
- the roll out of carbon-literacy training to our key stakeholders and decision-makers
- the cost-neutral creation of a new Energy and Decarbonisation Manager post within our Workplace Team, focused on optimisation of our approach to utilities consumption
- the continued roll out of habitat-preservation and bio-diversity initiatives across our sites, particularly at Torbay Hospital, including wild seed meadows, bug hotels, sensory walks, and bat and bird boxes
- conclusion of our heat decarbonisation plan referenced in the previous year's annual report, which is being owned by the Technical Centre of Excellence within the Workplace Team who plan to begin implementation in 2023/24
- developed and agreed a specification for a power purchasing agreement, delivering locally sourced renewable energy directly to our Torbay Hospital site in order to reduce reliance on more traditional energy sources. This opportunity will form part of an open-market, competitive tender process and awarded in the latter part of the 2023/24 strategic year.

- We ensure all our capital build projects embrace our transition to carbon net zero through the design and delivery of new infrastructure and equipment. This includes removing the need for gas and using solar and air heat source pump technologies in new builds.

While our green plan focuses on 2022-2025, we will ensure it is updated and expanded regularly, as and when there is a better understanding of our environmental impacts and how to reduce them.

### Social and community issues

We are clear about our leadership role in our local health and care system. As an anchor institution we are deeply connected to our local area and we use our influence, skills and resources to benefit the communities we serve.

We recognise we have a particular responsibility to help our children and young people start well in life, giving them a good foundation of health and wellbeing that will protect them against later ill-health, while also supporting their education, training and future job prospects.

We are working with our community partners to reduce the inequalities experienced by local people. We recognise the impact on employment on long term health outcomes and are committed to providing meaningful, flexible employment for local people as well as work experience and volunteering opportunities. Through the Torbay Advice Network supported pathway local people in receipt of adult social care receive additional support to obtain and maintain employment through advice and guidance with reasonable adjustments and an access to work scheme.

We have developed several new initiatives to support employment within our local community. This includes an alliance with our local further education provider, South Devon College, to develop pathways into health and care careers. During the year we launched our new health car support worker scheme to support people into much needed roles and began working in partnership with the job centre on the volunteer to career programme which supports people through volunteering into secure employment. We also joined the 16-18 year old's T levels scheme and expanded our placement opportunities with the first cohort of industrial placements offered this year.

We have also committed to sharing our apprenticeship levy programmes to give smaller employers in Torbay and South Devon opportunities to harness apprenticeship opportunities and we are developing a new work experience online platform to give everyone the opportunity to see what our local career opportunities. We are also working with private, voluntary and independent sector partner across Torbay and South Devon to broaden our reciprocal placements offer to help improve career prospects across the whole health and care sector.

We also recognise the impact of housing, education, environment, debt and many other factors on people's health and wellbeing and will continue to work closely with our communities and in partnership with others to do our bit in making life better for all. We are proud signatories of the Torbay community wealth building memorandum of understanding and we are working together with our partners to improve how we support the local economy from the goods that we buy, to the people that we employ, the assets that we own and the powers that we have to bring about positive change that will benefit local people.

In addition, our staff support many health-related groups in both a business and voluntary capacity. We support and enable our staff to play a full part in the community, for example by acting as governors for schools and colleges.

### Anti-bribery and human rights issues

Our internal processes ensure consistency with our zero-tolerance approach to bribery and we work closely with our Local Counter Fraud Specialist (LCFS) to raise awareness of our policies and procedures through local induction sessions and bespoke training. We have continued to use the management database system to support our compliance with NHSE guidance on managing conflicts of interest. have continued to run awareness campaigns to remind staff of the requirement to comply with NHSE guidance and the Bribery Act 2010.

We encourage anyone with a concern to speak out and report concerns through our governance processes and our policies and procedures.

Our people can raise concerns through internal channels, either via the Freedom to Speak Up Guardians (FTSU) or the LCFS. The FTSU and LCFS report regularly to the Board and the Audit Committee, respectively and the FTSU line management is direct to the Chief Executive. The FTSU Guardian has a standing invitation to the Board Sub-Committee with responsibility for workforce, staffing and wellbeing – the People Committee - and is a regular attendee.

As an organisation we recognise the benefits of ethical procurement and professional training. We endorse membership of the Chartered Institute of Procurement and Supply for our professional buying team. This includes the adoption of the Institute’s code of conduct, which is also included within our Standing Orders and Standards of Business Conduct. We encourage best practice within our supply chain by ensuring we are compliant with legislation. We also encourage our suppliers and contractors working on our behalf to challenge unethical behaviour and promote a ‘speak up’ culture.

The Trust has a Counter Fraud, Bribery and Corruption policy which deals with the specific issues in the title. The Trust’s policies relating to Conflicts of Interest, Gifts and Hospitality, and its Disciplinary policy link to Counter Fraud. Additionally, appropriate policies are reviewed throughout the year for Fraud resilience and, where applicable, are updated to protect the Trust from economic crime and wrongdoing. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients and staff.

We have a Board approved anti-slavery and human trafficking statement, which is published on our website. We are playing a leading role in the development of a Devon and Torbay modern slavery adult victims referral pathway protocol and the formulation of the memorandum of understanding between statutory agencies within the anti-slavery partnership.

## Important events since the end of the financial year

There are no important events since the end of the financial year to report.

Liz Davenport
Chief Executive
28 June 2023

# PART II – ACCOUNTABILITY REPORT

## Directors' Report

The directors are responsible for the preparation of the financial statements in accordance with Department of Health and Social Care Group Accounting Manual and that the account gives a true and fair view. The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance, business model and strategy.

## The Foundation Trust Board of Directors

Our Board of Directors ('the Board') has collective responsibility for the exercise of all our powers. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for the members of the organisation and for the public. Directors are jointly and severally responsible for all the decisions of the Board.

The Board of an NHS Foundation Trust is accountable for the stewardship of the organisation, our services, resources, staff, and assets. The arrangements established by a Board must be compliant with the legal and regulatory framework, protect and serve the interests of stakeholders, specify standards of quality and performance, support the achievement of organisational objectives, monitor performance, and ensure an appropriate system of risk management and internal control.

Our constitution specifies that the Board of Directors shall comprise a non-executive Chairman; other non-executive directors; and executive directors.

- To ensure the balance and effectiveness of the Board, our constitution further requires that: one of the Executive Directors shall be the Chief Executive
- the Chief Executive shall be the Accounting Officer
- one of the Executive Directors shall be the Chief Finance Officer
- one of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
- one of the Executive Directors shall be a registered nurse or a registered midwife
- the non-executive directors and Chairman together shall be greater than the total number of executive directors.
- the validity of any act of the organisation is not affected by any vacancy among the directors or by any defect in the appointment of any director.

Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted.

The Board is accountable to stakeholders for discharging its general duties and is responsible for organising and directing the affairs of our organisation and our services in a manner that will promote success and is consistent with good corporate governance practice, and, for ensuring that in carrying out our duties, we meet our legal and regulatory requirements. In doing so, the Board of Directors ensures that our organisation maintains compliance with its terms of authorisation and other statutory obligations.

The Board reserves some responsibilities to itself, delegating others to the Chief Executive and other Executive Directors or Committees of Directors. Those matters reserved to the Board are set out as a formal schedule which includes approval of:

- our long-term objectives and financial strategy
- annual operating and capital budgets
- changes to our senior management structure
- the Board's overall 'risk appetite'
- our financial results and any significant changes to accounting practices or policies
- changes to our capital and estate structure
- conducting an annual review of the effectiveness of internal control arrangements
- setting the corporate governance structure of its Board and Committees
- ensuring the Well-Led framework is central to the Board's oversight and assurance, utilising it within the Board's annual effectiveness review.

Our Board of Directors delegates responsibility to the Chief Executive to:

- enact the strategic direction of the Board of Directors
- manage risk
- achieve organisational compliance with the legal and regulatory framework
- achieve organisational objectives
- achieve specified standards of quality and performance
- operate within, generate, and capture evidence of the system of internal control.

## Board of Directors – disqualification

The following may not become or continue as a member of our Board of Directors:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged
- a person who has made a composition or arrangement with, or granted a Foundation Trust deed for his creditors and who has not been discharged in respect of it
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him
- a person who falls within the further grounds for disqualification as described in our constitution
- a person excluded from eligibility in accordance with the NHS Standard Form Licence Conditions, as issued from time to time.

## Composition of the Board of Directors

Our Board of Directors as at 31 March 2023 is shown below:

| Non-Executive Directors | Executive Directors |
|---|---|
| Richard Ibbotson – Chairman<br>Richard Crompton – Non-Executive Director and Vice Chair<br>Chris Balch – Non-Executive Director and Senior Independent Director<br>Jacqui Lyttle – Non-Executive Director<br>Vikki Matthews – Non-Executive Director Paul Richards – Non-Executive Director Robin Sutton – Non-Executive Director<br>Siân Walker-McAllister – Non-Executive Director | Liz Davenport – ChiefExecutive<br>David Stacey – Deputy Chief Executive and Chief Finance Officer<br>Ian Currie – Medical Director<br>Adel Jones – Director of Transformation and Partnerships<br>Deborah Kelly – Chief Nurse<br>Jon Scott – Chief Operating Officer<br>Michelle Westwood – Chief People Officer |

Note: Our Board has two non-voting Executive directors Dr Joanne Watson, Health and Care Strategy Director and Mrs Emily Long, Director of Corporate Governance and Trust Secretary. In addition, there is one non-voting associate non-executive director, Dr Peter Aitken.

Since the year-end there have been no changes in Board membership. The gender balance of the Board as at 31 March 2023 was:

| | Female | Male |
|---|---|---|
| **Non-Executive Directors** | 3 | 5 |
| **Executive Directors** | 4 | 3 |

Biographies of the members of the Board are provided in Appendix A.

## Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests which may conflict with their role and management responsibilities at our organisation. At each meeting of the Board of Directors, a standing agenda item also requires all Executive Directors and Non- Executive Directors to make known any interest in relation to the agenda and any changes to their declared interests. There are no interests which may conflict with their management responsibilities as per the requirements of the NHS Foundation Trust Code of Governance. The Chairman has no other significant commitments that affect his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

The Chief Executive's Office maintains a register of interests, and is available on our website or by contacting the Trust Secretary at the address given in Appendix B – Further information and contact details.

No political donations were made or received by the organisation in the reporting period.

## Independence of the Non-Executive Directors

Our Board of Directors has assessed the independence of the Non-Executive Directors and considers all current Non-Executive Directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement as evidenced through their declarations of interest, previous employment, or tenure.

## Committees of the Board of Directors

The Board has established the 'statutory' Committees required by the NHS Act 2006 and our constitution. The Non-Executive Nominations and Remuneration Committee and the Audit and Risk Committee each discharge the duties set out in our constitution and their terms of reference.

The Board has chosen to deploy additional ‘designated’ Committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and financial risk management. These are the Quality Assurance Committee, the Finance, Performance, Digital Committee, the People Committee and the Building a Brighter Future Committee.

The role, functions and summary activities of the Board’s Committees are described below:

### Non-Executive Nominations and Remuneration Committee

The purpose of the Non-Executive Nominations and Remuneration Committee is to conduct the formal appointment to, and removal from office, of Executive Directors, other than the Chief Executive who shall be appointed or removed by the Non- Executive Directors subject to approval by the Council of Governors. The Committee also considers succession planning for Executive Directors, considering the challenges and opportunities facing the organisation, and the skills and expertise that will be needed on the Board of Directors in the future.

We are also required to appoint a Remuneration Committee in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the Constitution, and the NHS Foundation Trust Code of Governance.

The Non-Executive Nominations and Remuneration Committee fulfils the dual purpose of the two statutory Committees for nomination and remuneration of Executive Directors. It also decides the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and reviews the suitability of structures of remuneration for other senior managers.

The Committee met on 15 occasions in the reporting period for the purpose of considering changes in remuneration for Executive Directors and other senior managers, receiving reports on the appraisals and objective setting for Executive Directors, Executive succession planning, and to lead on the appointments of Executive Directors, namely the Chief People Officer and Chief Operating Officer. The Committee was supported in the recruitment process by an external recruitment consultant. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any matters requiring disclosure to the Board.

### Audit and Risk Committee

The Audit and Risk Committee works in parallel with the Board’s Sub-Committees.

The terms of reference for the Audit and Risk Committee are published on the Trust’s website. The Audit and Risk Committee reviews the effectiveness of systems of governance, risk management and internal control across the whole of the organisation’s activities. In comparison, the Quality Assurance Committee reviews the actions being taken by the organisation to ensure the ongoing maintenance of standards of quality of care and improvements, where necessary, to patient experience.

- During the year the Audit and Risk Committee reviewed the adequacy of:all risk and control-related disclosure statements, together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- underlying assurance processes that indicated the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority
- the Committee’s terms of reference and work plan.

The Committee sought reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness; notably, the Committee-initiated improvements to the Board assurance framework.

As part of the year-end reporting process, the Chief Finance Officer presented a summary of the financial results, an overview of the financial statements and the key areas of judgment and estimation, building on the external audit risk assessment.

The committee also received an update on the implementation of IFRS 16.

The Committee met on five occasions in the reporting period and was attended by the Chief Finance Officer and other senior managers, including the Director of Operational Finance, Chief Nurse and Interim Director of Corporate Governance. A governor observer was also in attendance. Representatives from the external auditor (Grant Thornton), internal auditor (ASW Assurance) and our local counter fraud specialist attended each meeting. The Committee undertook a self-assessment during the year and also reviewed its terms of reference. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

The external auditor (Grant Thornton LLP) has not provided any additional non-audit services during the period.

### Audit and Risk Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accounting Officer for the Foundation Trust, the Audit and Risk Committee has examined the adequacy of systems of governance, risk management and internal control within the organisation, from information supplied, and formed the opinion that:

- there is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk
- assurances received are sufficiently accurate, reliable, and comprehensive to meet the Accounting Officer's needs and to provide reasonable assurance
- governance, risk management and internal control arrangements within the organisation include aspects of excellence as well as aspects in which ongoing attention to the control improvement is required
- financial controls are sufficient to provide reasonable assurance against material misstatement or loss
- the quality of both internal audit and external audit over the past year has met all the organisation's requirements.

The Committee discharged its role through the year as follows:

- we reviewed the establishment and maintenance of an effective system of governance, risk management and intern al control across the whole of the organisation's activities (both clinical and non-clinical)
- we ensured that there was an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee. The Committee reviewed and approved the internal audit plan, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. The audit plan was reviewed during the year to ensure it remained risk based
- we considered the major findings of internal audit's work (and management's response). The internal auditor had unrestricted access to the Chair of the Committee for confidential discussion

- we reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The key audit matters related to: ISA 240 revenue risk, valuation of land and buildings, management over-ride of controls, completeness of expenditure risk and, financial sustainability in respect of the organisation's arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the Annual Report and financial statements before submission to the Board
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made we reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the organisation.

### Quality Assurance Committee

The Board of Directors has established the Quality Assurance Committee to support the Board in discharging its responsibilities for monitoring the quality of the organisation's services. This includes the essential standards of quality (as determined by Care Quality Commission's registration requirements), and national targets and indicators (as determined by NHSE's Oversight Framework). The Committee's work plan is aligned to the organisation's corporate objectives and associated risks.

The Committee reviews the outcomes associated with clinical services and patient experience and, the suitability and implementation of risk mitigation plans regarding their potential impact on patient outcomes. The Committee is also required, as directed by the Board from time to time, to consider issues relating to quality where the Board requires this additional level of scrutiny.

During the year, the Committee considered:
- the Board assurance framework and corporate level risks
- data and quality and safety metrics in relation to never events, long stay patients with mental health and domiciliary care, Venous thromboembolism (VTE), stroke, maternity and serious incidents
- quality and safety risks in relation to operational matters and harm reviews
- clinical governance framework and associated priorities
- patient safety strategy
- progress against the Care Quality Commission improvement plan
- internal audit reports relating to patient safety and quality
- patient surveys that also included reports on patient experience
- the integrated quality, finance, and performance report from a quality and safety perspective
- the Quality Account and its priorities.

A programme of service reviews during the year was introduced during the year enabling the Committee to undertake a detailed deep-dive into specific services or specialties. To date the Committee has conducted deep-dives into the following:
- Torbay Drug and Alcohol Service
- stroke services (two deep dives in the reporting year)
- support for patients with complex mental health needs
- maternity and obstetrics.

The Committee met seven times during this reporting period. Along with Committee members, the Committee was attended by a number of senior managers, including System Directors of Nursing and Professional Practice, Clinical Service Leads and the Interim Director of Corporate Governance. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was also present at the majority of meetings. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

### Finance, Performance, and Digital Committee

The Finance, Performance and Digital Committee has delegated authority from the Board of Directors, subject to any limitations imposed by the schedule of matters reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- control and management of the finances of the organisation
- target level of efficiency savings and actions to ensure these are achieved
- budget setting principles
- year-end forecasting
- commissioning
- capital planning and delivery.

The Finance, Performance and Digital Committee met on 13 occasions during this reporting period. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend each meeting and was present at the majority of meetings. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

### People Committee

The purpose of the People Committee is to provide assurance to the Board on the following:

- national workforce guidance and strategies
- the people plan and associated activity/implementation plan(s) to support our forward strategy
- key people and workforce performance metrics and targets
- provide assurance on those elements of the Board assurance framework identified as the responsibility of the Committee
- availability and opportunity for freedom to speak up and employee voice, and plans to improve staff experience in line with national staff survey findings.
- strategic people and workforce issues at national and local level
- act as an early point of contact for the FTSU Guardian to raise concerns prior to reporting to Board.

During the year, the Committee has considered:

- review of the Board assurance framework and corporate risk register, with appropriate challenge to the proposed controls and risk scoring
- deep-dives in to the achievement reviews, just and learning culture, attraction and retention of talents
- received reports on progress against our people promise and plan
- received assurance reports around education and workforce development
- reviewed the workforce information including pay and absence information
- reviewed talent management and succession planning arrangements
- received reports on the Workforce Transformation Programmes
- triangulated information to reconcile headcount and finance data.

The People Committee meets on a bi-monthly basis and is chaired by a Non- Executive Director. The Committee membership also includes two further Non- Executive Directors, Chief People Officer, Chief Operating Officer, the Chief Nurse and the Medical Director. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

### Building a Brighter Future Committee

The Building a Brighter Future Committee was established for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme 'Building a Brighter Future' and to support the successful achievement of the programme investment objectives and realisation of the stated benefits. The Committee also provides assurance around the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirms that projects are delivering the stated benefits, are value for money, and are ultimately affordable.

The Building a Brighter Future Committee meets on a monthly basis and is chaired by a Non-Executive Director. The Committee also comprises two further Non- Executive Directors, Medical Director, Chief Finance Officer and the Senior Responsible Officer/ Programme Sponsor. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

### Enhanced quality governance reporting

The Board was satisfied during the year that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information), the organisation had, and will keep in place, effective leadership arrangements for monitoring and continually improving the quality of health and social care, including:

- ensuring required standards are achieved (internal and external)
- investigating and acting on substandard performance
- planning and managing continuous improvement
- identifying, sharing, and ensuring delivery of best-practice
- identifying and managing risks to quality of care.

This encompasses an assurance that due consideration was given to the quality implications of plans (including service redesigns, service developments and cost improvement plans), in the form of quality and equality impact assessments, and that processes are in place to monitor their ongoing impact on quality and take subsequent action, as necessary, to ensure quality is maintained.

The basis of the Board of Directors confirmation was set out in the draft corporate governance statement to be submitted to NHSE. The Annual Governance Statement provides further information.

## Membership and attendance at Board and Committee meetings

The Board of Directors discharged its duties during 2022/23 in ten meetings, and through the work of its Committees. The Chairman of the Board submitted a report to the Council of Governors (CoG) at each meeting, highlighting any matters requiring disclosure to the Council.

The table overleaf shows the membership and attendance of voting board members who attend meetings of the Board and Board Committees during the year.

| 2022-23 | Board of Directors | Council of Governors | Non-Executive Director Nominations and Remuneration Committee | Audit Committee | Quality Assurance Committee | Finance, Performance, and Digital Committee | People Committee | Building a Brighter Future Committee |
|---|---|---|---|---|---|---|---|---|
| Number of meetings | 10 | 4 | 14 | 5 | 7 | 13 | 6 | 9 |
| Richard Ibbotson | C10(10) | C4(4) | C14(14) | - | - | - | - | - |
| Chris Balch | 10(10) | 4(4) | - | 5(5) | - | 13(13) | 6(6) | C9(9) |
| Richard Crompton* | 4(6) | 3(3) | 1(3) | 1(1) | - | C3(3) | - | 3(6) |
| Jacqui Lyttle | 4(10) | 2(4) | 7(14) | 4(5) | C5(7) | - | - | - |
| Vikki Matthews | 7(10) | 3(4) | 8(14) | 4(5) | 4(7) | - | 6(6C | - |
| Paul Richards | 10(10) | 4(4) | - | 4(4) | - | C10(10) | - | 8(9) |
| Robin Sutton | 10(10) | 4(4) | - | C1(1) | - | 13(13) | - | - |
| Sally Taylor** | 6(7) | 2(3) | 10(11) | C4(4) | - | - | - | - |
| Siân Walker-McAllister | 5(6) | 2(2) | - | - | 4(4) | - | 3(3) | - |
| Liz Davenport | 10(10) | 3(4) | - | - | - | - | - | - |
| Ian Currie | 10(10) | 3(4) | - | - | 7(7) | 11(13) | 6(6) | 6(9) |
| Judy Falcão# | 4(4) | 0(1) | - | - | 1(1) | - | 2(3) | - |
| Sheridan Flavin## | 2(2) | 2(2) | - | - | 1(3) | - | 2(2) | - |
| John Harrison ^ | 5(5) | 1(4) | - | - | 1(4) | 4(7) | 0(3) | - |
| Adel Jones | 9(10) | 2(4) | - | - | - | 12(13) | - | 7(9) |
| Deborah Kelly | 9(10) | 3(4) | - | 3(5) | 6(7) | 8(13) | 5(6) | - |
| Jon Scott^^ | 4(5) | 2(2) | - | - | 2(3) | 5(6) | 1(2) | - |
| David Stacey | 10(10) | 3(4) | - | 5(5) | - | 13(13) | - | 7(9) |
| Michelle Westwood~ | 4(4) | 1(4) | - | - | 3(3) | - | 2(2) | - |
| * Richard Crompton – commenced 01.08.22 | | | | | | | | |
| **Sally Taylor – left 31.12.22 | | | | | | | | |
| ***Siân Walker-McAllister – commenced 01.09.22 | | | | | | | | |
| #Judy Falcão – left 11.07.22 | | | | | | | | |
| ##Sheridan Flavin – commenced 12.07.22, left 26.11.22 | | | | | | | | |
| ^John Harrison – left his role as Chief Operating Officer on 17.10.22 | | | | | | | | |
| ^^Jon Scott – commenced 18.10.22 | | | | | | | | |
| ~Michelle Westwood – commenced 27.11.22 | | | | | | | | |

Figures in brackets indicate the number of meetings the individual could be expected to attend by their membership of the Board or Committee. A dash indicates that the individual was not a member. ‘C’ denotes the Chair of the Board or Committee.

## Performance of the Board and Board Committees

Members of the Board are subject to on-going and regular performance appraisal. The Chief Executive appraises individual Executive Directors. Non-Executive Directors and the Chief Executive are appraised by the Chairman. The Chairman was appraised by the Senior Independent Director for 2022/23 in accordance with the guidance issued by NHSE ‘Framework for conducting annual appraisals of NHS provider chairs’.

The outcome of these appraisal processes was presented to the governors’ Nominations and Appointments Committee and confirmed with the Council of Governors. Confirmation of the process undertaken in respect of the Chairman’s appraisal has been submitted to the NHSE in accordance with the aforementioned guidance.

The Board of Directors undertakes a regular self-assessment of its performance to establish whether it has adequately and effectively discharged its role, functions, and duties.

For the reporting period, the Board’s performance, considering the role, function, and work of the Board Committees, was of the requisite standard. The Board believes that it is balanced and complete in its composition and appropriate to the requirements of the organisation. This was attributed to the comprehensive annual cycle of reporting, a robust Board assurance framework and risk register, and a development plan undertaken under the guidance of the Chair and Trust Secretary.

The findings of the internal audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusion.

Similar assessment exercises were undertaken for each of the Committees of the Board, all of which were considered to have fully discharged the duties set out in their terms of reference.

## The Council of Governors

The Council of Governors is responsible for discharging the general duties set out in legislation which are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the organisation as a whole and the interests of the public.

The Council of Governors discharged its statutory duties as set in the NHS Code of Governance supported through its sub-committees and working groups.

It remains the responsibility of the Board of Directors to design and implement the organisational strategy. The Council of Governors and the Board of Directors communicate principally through the Chairman who is the formal conduit and Chairman of the two bodies. This relationship is formally extended and augmented by governors and directors' participation in Board to Council meetings to ensure constant and clear communication and co-operation between the Board and the Council of Governors. Additionally, directors regularly attend meetings of the Council of Governors. During the reporting year, hybrid meetings have taken place, both face to face and with delegates joining via MS Teams.

The Board of Directors may request the Chairman to seek the views of the Council of Governors on any matters it may determine. Communications and consultations between the Council of Governors and the Board include, but are not limited to the following topics:

- our annual plan
- the Board's strategic proposals
- clinical and service priorities
- proposals for new capital developments
- engagement of our membership and the public.

The Board of Directors presents the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors.

Detailed information on the composition of our Council of Governors can be found in the tables overleaf.

| Public constituencies | | | |
|---|---|---|---|
| Name | Constituency | Tenure | CoG Attendance |
| Dave Cawley | South Hams and Plymouth | Elected – 01 March 2022 | 3 (4) |
| Craig Davidson | South Hams and Plymouth | Re-elected – 01 March 2022 | 3 (4) |
| Val Browning | South Hams and Plymouth | Elected - 01 March 2023 | 0 (0) |
| *Jean Thomas | Teignbridge | Elected – 01 March 2021 | 4 (4) |
| Loveday Densham | Torbay | Elected – 01 March 2021 | 4 (4) |
| Steven Harden | Torbay | Elected – 01 March 2020<br>(Did not stand for re-election – completed term of office on 28.02.2023) | 2 (4) |
| Eileen Engelmann | Teignbridge | Re-elected – 01 March 2022 | 4 (4) |
| Annie Hall | Teignbridge | Re-elected – 01 March 2022 | 3 (4) |
| Michael James | Teignbridge | Re-elected – 01 March 2022 | 1 (4) |
| John Smith | Teignbridge | Re-elected – 01 March 2022 | 3 (4) |
| Jan Goodman | Teignbridge | Elected – 01 March 2023<br>Resigned – 01 August 2022 | 1 (1) |
| Andrew Postlethwaite | Teignbridge | Elected – 01 March 2023 | 0 (0) |
| James Hartley | Teignbridge | Elected – 01 March 2023 | 0 (0) |
| *Andrew Stilliard | Torbay | Elected – 01 March 2020<br>Re-elected – 01 March 2023 | 2 (4) |
| John Kiddey | Torbay | Elected – 01 March 2020<br>(Stood but was not re-elected in 2023 round of elections, however took over the remaining term left vacant by Mark Tyrell-Smith as the candidate with the next highest number of votes) | 4 (4) |
| Keith Yelland | Torbay | Elected – 01 March 2021 | 3 (4) |
| Mark Tyrrell-Smith | Torbay | Elected 01 March 2021<br>Resigned – 10 June 2021<br>(moved out of Teignbridge consistency)<br>Re-elected 01 March 2022<br>Resigned – 28 February 2023 | 4 (4) |
| Peter Milford | Torbay | Elected – 01 March 2022 | 4 (4) |
| Alison Ramon | Torbay | Elected – 01 March 2023 | 0 (0) |
| Lee Thomas | Torbay | Elected – 01 March 2023 | 0 (0) |
| *Appointed 04 May 2022: Lead Governor, Jean Thomas, Deputy Lead Governor Andrew Stilliard | | | |

| Staff-elected governors (staff constituency), six representatives (two vacancies) | | | |
|---|---|---|---|
| Name | Class | Tenure | CoG Attendance |
| Matthew Giles (Nee Arthur) | Paignton and Brixham ISU | Elected – 01 March 2021 | 1 (4) |
| Emily Wood (Nee Huggins) | Trustwide Operations and Corporate Services ISU | Elected – 01 March 2021 | 2 (4) |
| Radia Woodbridge | Moor to Sea ISU | Elected – 01 March 2021 | 3 (4) |
| Sal Aziz | Torquay ISU | Elected – 01 March 2023 | 0 (0) |
| Johnathan Shribman | Newton Abbot ISU | Elected – 01 March 2023 (previously Governor for South Hams and Plymouth for one term) | 2 (4) |
| *Vacancy* | Coastal ISU | | |
| Deborrah Kelly | Torquay ISU | Elected – 01 March 2023 Resigned 18 October 2022 | 2 (2) |

| Appointed governors (partner organisations) | | | |
|---|---|---|---|
| Name | Organisation | Tenure | CoG Attendance |
| Derek Blackford | Devon CCG | Re-appointed – 01 April 2020 | 1(4) |
| Jonathan Hawkins | Devon County Council | Appointed – 14 May 2019 | 2 (4) |
| Nicole Amil | Torbay Council | Re-appointed – 01 October 2020 | 4(4) |
| Rosemary Rowe | South Hams District Council | Appointed – 25 July 2019 (did not stand for reappointment in local council elections) | 3 (4) |
| Lorraine Evans | Teignbridge District Council | Appointed 18.06.2019 Resigned August 2022 | 0 (2) |
| Chrissie Thirwell | University of Exeter Medical School | Appointed 01 March 2023 | 0 (0) |
| Andrew MacGregor | Teignbridge District Council | Appointed 01 March 2023 | 0 (0) |
| Clare McAdam | South Hams District Council | Appointed 01 March 2023 | 0 (0) |
| Louise Winfield | Plymouth University Peninsula Schools of Medicine and Dentistry | Appointed 01 March 2023 | 0 (0) |
| Hilary Milner | Devon Carers | Appointed 01 March 2023 | 0 (0) |

## Governor elections

In order to refresh the Council of Governors and bring a diverse range of views into our organisation, elections are held every year. These elections are held in the various geographical or staff constituencies as set out in our constitution. During this year, the following elections were held with each member being offered a three-year term of office.

| Constituency | Candidate | Result | Voting % |
|---|---|---|---|
| Torbay | Alison Ramon | Elected | 16.1% |
| Torbay | Andrew Stilliard | Elected | |
| Teignbridge | James Hartley | Elected | 13.6% |
| Teignbridge | Andrew Postlethwaite | Elected | |
| South Hams & Plymouth | Val Browing | Elected unopposed | N/A |
| Staff Governor (Newton Abbot ISU) | Jonathan Shribman | Elected unopposed | N/A |
| Staff Governor (Torquay ISU) | Sal Aziz | Elected unopposed | N/A |

## Governors' interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as governors. Our membership office maintains a register of interests which is published on our website.

## Committees of the Council of Governors

The Council of Governors has appointed one standing Committee and one working group. Further information on these can be found below.

## Governors' Nomination and Remuneration Committee

The Governors' Nomination and Remuneration Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, our constitution, and the NHS Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to appointments, remuneration and other terms of service of the Chairman and Non-Executive Directors. Its functions include:

- to receive advice as directed by the regulator and determine overall remuneration and terms and conditions of service for the Chairman and Non- Executive Directors
- to recommend to the Council of Governors the levels of remuneration and terms and conditions of service for Chairman and Non-Executive Directors
- to monitor the performance of the Non-Executive Directors through the Chairman
- to monitor the performance of the Chairman through the Senior Independent Director
- to undertake a periodic review of the numbers, structure, and composition (including the person specifications) of the Chairman and Non-Executive
- Directors, to reflect the expertise and experience required, and to make recommendations to the Council of Governors
- to develop succession plans for the Chairman and Non-Executive Directors, considering the size and composition of the organisation
- identify and nominate candidates to fill the Chairman and Non-Executive Director posts as they arise.

The Committee met eight times during the year to consider remuneration levels for Non-Executive Directors, re-appointment of the Chairman and Non-Executive Directors, determine the process for appraising the performance of the Chairman and Non-Executive Directors and reviewed the succession plan for Non-Executive Directors. In considering the remuneration levels and the performance appraisal process, the Committee took in to account the guidance issued by NHSE and ensured processes were in line with that guidance. The Committee also undertook a self-assessment of its effectiveness and reviewed its terms of reference.

## Membership Committee

The Membership Committee is a formal Committee established in accordance with our constitution for monitoring, maintaining, and advancing the membership. Its primary purpose is:

- advice by offering advice and information to the Council of Governors on the community perception of our conduct of our healthcare provision
- recruitment by seeking to maintain the registered membership at its present level and to maintain under review means of achieving a representation of all sectors of the community
- information by promoting a series of seminars and events for members and members of the public, focusing on significant sectors of our work
- engagement by promoting communications to and from members.

The Committee continued to meet virtually during 2022/23, using MS Teams. Limited person and face-to-face engagement with members took place with email and social media being the primary means of communication and engagement in 2022/23.

## Membership and meetings of the Council of Governors

Membership is free and aims to give local people and staff a greater influence over how our services are provided and developed. It also helps us to work much more closely with local people and the people who use our services. Our members have the chance to find out more about the hospitals, our community services, the way they are run and the challenges they face, and furthermore, help us work with local people to improve the care and experience of patients and their carers'.

We had 15,344 members as at 31 March 2023, split between 8, 128* public members and 7,216 staff members. The public constituencies of South Hams and Plymouth. Teignbridge, Torbay and Rest of the South West Peninsula comprised 967 members, 2,999 members, 4,058 member and one member, respectively. Public membership is open to people aged 14 or over and who live within our defined membership area. During the reporting year, a data cleanse exercise was undertaken which provided members with the opportunity to check and update the details we hold for them. All eligible staff automatically become staff members unless they choose to opt out. Staff are eligible for membership provided that they hold a permanent contract of employment with us or they have been employed by us on a temporary contract of 12 months or longer.

(*There is a discrepancy of 103 between the total number of public members and members in each public constituency. This is due to the constituency data being requested after the year end reflecting changes in membership numbers)

The Council of Governors met on a total of four occasions during 2022/23. In the reporting period, the majority Council of Governors meetings have been held virtually, via MS Teams. A virtual Annual Members' Meeting was held at which the Annual Report was presented to the governors by the Board.

During 2022/23 the Council of Governors held two formal meetings with our Board of Directors. Following a review of meetings as part of the Council of Governor's work to review its structure, supported by the Good Governance Institute, the decision was made to stand down formal Board to Council of Governors meetings. These have been replaced with informal bi-monthly 'Council of Governor Priorities' meetings, which Non-Executive and Executive Board members are invited to attend at the Governor's discretion depending on the matters being discussed.

### Performance of the Council of Governors

The Council of Governors is required to undertake a regular self-assessment of its performance year to establish whether it has adequately and effectively discharged its role, functions, and duties during the preceding year. During 2022/23 the Council of Governors undertook a series of workshops, supported by the Good Governance Institute to improve the function of the Council and Governors. This included a self-assessment exercise. Following the workshops an action plan was developed and continues to be implemented.

### NHS oversight framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

### Segmentation

On 22nd November 2022, it was confirmed that we have now been placed into OF segment 4 from segment 3 and would therefore receive further bespoke mandated support. The reason for the segment 4 rating was our underlying financial deficit and operational performance improvement requirements.

In response to our segment four rating, we are developing a series of timebound and measurable performance obligations to exit segment 4. These have been agreed with ICB Devon and NHSE. Progress against the exit criteria is BEING regularly scrutinised through our governance processes and reported monthly to the system improvement and assurance group.

This segmentation information is the trust's position as at 28 June 2023. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

## Well Led

The Trust has due regard to the well-led framework in arriving at its overall evaluation of the organisation's performance, internal controls and board assurance framework. Its principles also underpin our strategy, approach to risk management and are utilised to review Board and Committee effectiveness. Greater detail of our approach with regard to clinical services can be found within our Quality Account 2022/23 and more broadly within this Annual Report; notably within the Performance Report and Governance Statements; which explore both our performance and governance framework more broadly.

During the reporting period 2022/23, we had no formal CQC inspections but continued to work in partnership with the CQC via our regular planned contact. This scheduled activity includes our monthly CQC meetings with our local inspector and inspection manager as well as the quarterly engagement meetings. These meetings have executive involvement and are a good vehicle for open discussion and sharing between ourselves and the CQC.

We also continued our audit and assurance work to ensure risk assessments were completed for each patient within 24 hours of admission to hospital and in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken.

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an integrated service unit (ISU) level, as well as at the nutritional steering group and by exception to the quality improvement group.

## Patient Care

Our Quality Goals, expanded upon within our Quality Account 2022/23 outlines our commitment and strategy for improved, personalised, patient care. Our Quality Goals for 2022/203 were:

Quality priority one: improve identification and management of sepsis
Quality priority two: improve compliance around patient risk assessments
Quality priority three: improved identification of deteriorating patient
Quality priority four: improved experience for people being discharged

Assessment of our progress and performance against these is referred to within the Performance report as well as being explored in more detail in our Quality Account 2022/23.

## Stakeholder relations

In addition to our partnership working, we engage directly with other stakeholders including our patients, service users, carers, families, and the public to understand, listen and where possible adapt or change the services we offer and recognise the value of their ideas about these how services can be developed and improved.

Our Board of Directors recognises the importance of understanding the experiences of people who use our services and continues its commitment to receive a story regularly at Board meetings.

With such a large public membership, this allows the organisation to harness and utilise the experience of our members, who provide us with knowledgeable information. Our governors attend our Board sub-committee's as observers and patient representatives also attend important groups such as the patient feedback and engagement group, quality improvement group and mortality surveillance group, so that we can better understand the experiences and needs of people who use our services.

Information and feedback are received from many quarters including national surveys and local surveys. We resumed the Friends and Family Test and aim to resume real time inpatient experience survey soon which is led by our working with us volunteers and supported through clinical effectiveness and consultations. These provide a rich source of data and with the national surveys provide benchmark data we can use for comparisons. We also receive valuable ideas and suggestions from well-established patient pathways, social media and our patient and service user groups.

We also work with external organisations such as Healthwatch and seAp (a charity providing independent and confidential advocacy services), both of which help us hear the voices of people who use our services more clearly. We are committed toworking in partnership to improve how we listen to, and use, people's experiences to improve our services.

The Council of Governors' Membership Committee, focusses on ensuring there is an ongoing dialogue with members and that we continue to develop the membership to make it as representative of the whole community as possible. Public membership at the end of March 2022 totalled 8,721 and 8,128 at the end of March 2023. Members of the public, living in any of the three public constituencies and aged over 14, are eligible to become members.

## Other disclosures

### Fees and charges (income generation)

Costs associated with fees and charges levied by the organisation are set out in note 5 to the annual accounts.

### Income disclosures required by Section 43(2A) of the NHS Act 2006

As disclosed in the Foundation Trust's annual accounts, the Foundation Trust complies with the need to ensure that income from the provision of goods and services for health services in England is greater than its income from the provision of goods and services for any other purpose; Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

The other income that the Foundation Trust receives either fully covers the cost of those services or for income generating activities, profit is directly reinvested into the provision of health and social care.

## Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement & NHS England.

## Better payment code of practice

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

No payments were made during the year (2020/21: £Nil) under the Late Payment of Commercial Debts (Interest) Act 1998.

| | 2022/23 | | 2021/22 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total Non-NHS trade invoices paid in the year | 143,838 | 325,511 | 145,108 | 286,203 |
| Total Non-NHS trade invoices paid within target | 117,653 | 268,218 | 123,927 | 240,117 |
| Percentage of Non-NHS trade invoices paid within target | 82% | 82% | 85% | 84% |
| | | | | |
| Total NHS trade invoices paid in the year | 1,849 | 31,540 | 2,093 | 26,773 |
| Total NHS trade invoices paid within target | 943 | 25,455 | 1,113 | 20,663 |
| Percentage of NHS trade invoices paid within target | 51% | 81% | 59% | 77% |

## Counter fraud policies and procedures

We have a clear strategy for tackling fraud, corruption and bribery. This is documented in our counter fraud, bribery and corruption policy which details responsibilities and how to report suspicions of fraud, bribery or corruption.

We have a lead accredited Local Counter Fraud Specialist (LCFS) via consortium arrangements with ASW Assurance. In addition, we have a number of nominated support personnel from within the consortium that are able to support the organisation as required. The LCFS ensures risks are mitigated and systems are resilient to fraud, corruption and bribery. An annual counter fraud work plan is reviewed and approved by the Audit and Risk Committee.

The Deputy Chief Executive and Chief Finance Officer and the Audit Committee oversee the work of the LCFS. Reports on progress with delivery together with outlines of referrals received and investigations are regularly provided to the Audit Committee. The LCFS also highlights to the Committee any issues that have arisen so that appropriate action can be taken.

The program of counter fraud work was delivered in 2022/23 addressing all components of the Government Functional Standard GovS 013: Counter Fraud and NHS Counter Fraud Authority strategy. The LCFS develops and maintains key relationships across the organisation and this, coupled with the work undertaken by the LCFS, has resulted in the development of a strong anti-fraud culture.

### Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement and NHS England.

## Accessible Information Standard

### Making health and social care information accessible

From 01 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Healthwatch in Devon, Plymouth, and Torbay is the independent consumer champion for health and social care services, ensuring the voice of the community is used to influence and improve services for local people. They worked with the local deaf community and undertook an independent review of NHS services across Devon to ascertain how accessible their services were to them. They provided recommendations and suggestions for improvement and in response an action plan is being developed which will entail collaboration with the deaf community and other key partners.

## Statement as to Disclosure to Auditors (s418)

- The Board of Directors reports that for everyone who is a director at the time this report is approved: as far as the director is aware, there is no relevant audit information of which our auditor is unaware
- the director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that our auditor is aware of that information.
- Relevant audit information' means information needed by our auditor in connection with preparing their report. A director is regarded as having taken all the steps that they ought to have taken as a director to do the things mentioned above, and:
- made such enquiries of their fellow directors and of the corporation's auditors for that purpose
- taken such other steps (if any) for that purpose, as are required by their duty as a director of the company to exercise reasonable care, skill, and diligence.

The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the organisation's performance, business model and strategy.

Liz Davenport
Chief Executive
28 June 2023

## PART III – REMUNERATION REPORT

Salary and pension entitlements of senior managers as at 31 March 2023 (audited information)

| | 2021-22 | | | | | | 2022-23 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Salary | Expense Payments (taxable) | Annual Performance Pay and Bonuses | Long-term Performance Pay and Bonuses | All Pension Related Benefits | Total | Salary | Expense Payments (taxable) | Annual Performance Pay and Bonuses | Long-term Performance Pay and Bonuses | All Pension Related Benefits | Total |
| | (bands of £5,000) | (to nearest £100) | (bands of £5,000) | (bands of £5,000) | (bands of £2,500) | (bands of £5,000) | (bands of £5,000) | (to nearest £100) | (bands of £5,000) | (bands of £5,000) | (bands of £2,500) | (bands of £5,000) |
| **Name and Title** | £000 | £ | £000 | £000 | £000 | £000 | £000 | £ | £000 | £000 | £000 | £000 |
| **Mrs L Davenport**<br>Chief Executive | 190-195 | 0 | 0 | 0 | 60-62.5 | 250-255 | 200-205 | 0 | 0 | 0 | 70-72.5 | 270-275 |
| **Mr D Stacey**<br>Chief Finance Officer and Deputy Chief Executive | 150-155 | 0 | 0 | 0 | 47.5-50 | 200-205 | 160-165 | 0 | 0 | 0 | 0 | 160-165 |
| **Dr R G Dyer**<br>Deputy Chief Executive<br>(retired 05 July 2021) | 55-60 | 0 | 0 | 0 | 0 | 55-60 | | | | | | |
| **Mr I Currie**<br>Executive Medical Director | 210-215 | 0 | 0 | 0 | 247.5-250 | 460-465 | 220-225 | 0 | 0 | 0 | 310-312.5 | 525-530 |
| **Ms D Kelly**<br>Chief Nurse | 125-130 | 0 | 0 | 0 | 0 | 125-130 | 130-135 | 0 | 0 | 0 | 0 | 130-135 |
| **Ms A Jones**<br>Director of Transformation and Partnerships | 120-125 | 0 | 0 | 0 | 5.0-7.5 | 130-135 | 125-130 | 0 | 0 | 0 | 30-32.5 | 160-165 |
| **Mrs J Falcão**<br>Director of Workforce and Organisational Development (retired 11 July 2022) | 120-125 | 0 | 0 | 0 | 35-37.5 | 155-160 | 30-35 | 0 | 0 | 0 | 5.0-7.5 | 35-40 |
| **Mr J Harrison**<br>Chief Operating Officer (executive duties ceased 17 October 2022) | 125-130 | 0 | 0 | 0 | 55-57.5 | 180-185 | 65-70 | 0 | 0 | 0 | 0 | 65-70 |
| **Dr J Watson**<br>Health and Care Strategy Director | 170-175 | 0 | 0 | 0 | 112.5-115 | 285-290 | 170-175 | 0 | 0 | 0 | 40-42.5 | 210-215 |
| **Mrs E Long**<br>Director of Corporate Governance and Trust Secretary | 35-40 | 0 | 0 | 0 | 10-12.5 | 45-50 | 25-30 | 0 | 0 | 0 | 27.5-30 | 50-55 |
| **Mr O Raheem**<br>Interim Director of Corporate Governance and Trust Secretary<br>(left 14 February 2023) | 10-15 | 0 | 0 | 0 | 7.5-10 | 20-25 | 75-80 | 0 | 0 | 0 | 25-30 | 105-110 |
| **Mr J Scott**<br>Interim Chief Operating Officer<br>(appointed 03rd October 2022) | | | | | | | 150-155 | 3,100 | 0 | 0 | 0 | 150-155 |
| **Ms ST Flavin**<br>Interim Chief People Officer<br>(appointed 07 June 2022, left 02 December 2022) | | | | | | | 95-100 | 0 | 0 | 0 | 0 | 95-100 |
| **Dr M Westwood**<br>Chief People Officer<br>(appointed 01 November 2022) | | | | | | | 50-55 | 0 | 0 | 0 | 7.5-10 | 55-60 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sir R Ibbotson**<br>Non-Executive Chairman | 50-55 | 1,000 | 0 | 0 | | 50-55 | 50-55 | 2,500 | 0 | 0 | | 50-55 |
| **Mrs S Taylor**<br>Vice Chair / Non- Executive Director(retired 31 December 2022)) | 15-20 | 0 | 0 | 0 | | 15-20 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mrs J Lyttle**<br>Non-Executive Director and Senior Independent Director<br>(SID until 31 December 2022) | 10-15 | 0 | 0 | 0 | | 10-15 | 15-20 | 0 | 0 | 0 | | 15-20 |
| **Mr J Welch**<br>Non-Executive Director<br>(Retired 30 September 2021) | 5-10 | 0 | 0 | 0 | | 5-10 | | | | | | |
| **Mr R Sutton**<br>Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mr P Richards**<br>Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mrs V Matthews**<br>Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Prof C Balch**<br>Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Dr S Wollaston**<br>Non-Executive Director (commenced 0**1 October 2021**, left 29 November 2021) | 0-5 | 0 | 0 | 0 | | 0-5 | | | | | | |
| **Mr R Crompton**<br>Non-Executive Director<br>(appointed 011st August 2022) | | | | | | | 5-10 | 0 | 0 | 0 | | 5-10 |
| **Ms S Walker- McAllister**<br>Non-Executive Director<br>(Appointed 011st September 2022) | | | | | | | 5-10 | 0 | 0 | 0 | | 5-10 |
| **Dr P Aitken**<br>Associate Non-Executive Director<br>(appointed 011st January 2023) | | | | | | | 0.0-5.0 | 0 | 0 | 0 | | 0.0-5.0 |

Notes:

Dr P Aitken was appointed on 011st January 2023
Mr R Crompton was appointed on 011st August 2022
Dr R G Dyer retired on 055 July 2021.
Dr J Watson's remuneration is inclusive of clinical, operational as well as Trust Board duties.
Mr O Raheem was appointed on 15 February 2022 as Interim Director of Corporate Governance and Trust Secretary, and left the Trust on 14 February 2023.
Ms J Falcão retired on 11 July 2022.
Ms S Flavin was appointed as Interim Chief People Officer on 077th June 2022 and left on 022nd December 2022.
Dr M Westwood was appointed on 041st November 2022 as Chief People Officer.
Mr J Harrison's Executive duties ceased on 17 October 2022.

Mr J Scott was appointed on the 033rd October 2022 as Interim Chief Operating Officer.
Mrs S Taylor retired on 31 December 2022
Mrs Siân Walker-McAllister was appointed on 011st September 2022
Mr J Welch retired on 30 September 2021
Mrs Emily Long (on maternity leave February 2022 to February 2023).
Dr S Wollaston was appointed on 011st October 2021 but left on 29 November 2021 to take up another NHS appointment.
The following have opted out of the pension scheme: Ms D Kelly before joining the trust, Mr J Scott and Ms S Flavin.
The taxable benefits are in respect of travel expenses that are subject to income tax. None of the Directors received any annual or long-term performance-related benefits.

Page 65 (page number changed will be updated in final version) refers to managers who are paid more than £142,500 per annum (not including pension related benefits).

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## Pension benefits as at 31 March 2023 (audited information)

| Name and title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 1 April 2021 £000 | Real Increase / (Decrease) in Cash Equivalent Transfer Value £000 | Cash Equivalent Transfer Value at 31 March 2022 £000 | Employers Contribution to Stakeholder Pension (to nearest £100) £000 |
|---|---|---|---|---|---|---|---|---|
| **Mrs L Davenport** Chief Executive | 2.5-5.0 | 0.0-2.5 | 90-95 | 200-205 | 1,779 | **91** | 1,954 | 0 |
| **Mr I Currie** Executive Medical Director | 15-17.5 | 32.5-35 | 100-105 | 275-280 | 2,013 | **0** | 158* | 0 |
| **Mr D Stacey** Chief Finance Officer and Deputy Chief Executive | 0.0-2.5 | 0 | 20-25 | 0 | 202 | **0** | 212 | 0 |
| **Ms A Jones** Director of Transformation and Partnerships | 2.0-2.5 | 0.0-2.5 | 40-45 | 65-70 | 582 | **26** | 643 | 0 |
| **Mrs J Falcão** Director of Workforce and Organisational Development (retired 11 July 2022) | 0.0-2.5 | 0 | 50-55 | 105-110 | 980 | **0** | 823** | 0 |
| **Mr J Harrison** Chief Operating Officer (Executive duties ceased 17 October 2022) | 0-2.5 | 0 | 40-45 | 80-85 | 764 | **0** | 811 | 0 |
| **Mrs E Long** Director of Corporate Governance and Trust Secretary | 0-2.5 | 0 | 0-5.0 | 0 | 7 | **10** | 21 | 0 |
| **Mr O Raheem** Interim Director of Corporate Governance and Trust Secretary | 0-2.5 | 0 | 0-5.0 | 0 | 8 | **12** | 31 | 0 |
| **Dr M Westwood** Chief People Officer (appointed 1st November 2022) | 0-2.5 | 0 | 0-5.0 | 0 | 0 | **1** | 8 | 0 |
| **Dr J Watson** Health and Care Strategy Director | 2.5-5.0 | 0-2.5 | 65-70 | 130-135 | 1,227 | **55** | 1,337 | 0 |

*Mr I Currie CETV not required to be disclosed.
**Mrs J Falcão retired on 055th July 2021. At which point the pension began to be drawn. Accordingly, the CETV of Mrs Falcão's pension at 31 March 2023 is not available
***Mrs Emily Long (on maternity leave February 2022 to February 2023).

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued because of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member because of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

## Annual Statement on Remuneration

There have been no changes to the remuneration policy for senior managers during the year.

For Executive Directors there are no arrangements relating to termination payments other than the application of employment contract law. No termination payments have been made to either present or past senior managers within 2022/23.

The Non-Executive Directors Nomination and Remuneration Committee (the Committee), whose function it is to decide pay for Executive Directors conduct a review of executive salaries each year.

During the year ending 31 March 2023, four senior managers (Chief Executive, CFO & Deputy Chief Executive, Medical Director and the Health & Care Strategy Director (including payment for role as a Consultant) were paid more than £142,500. The steps outlined above provides the Non-Executive Nominations and Remuneration

Committee with assurance that the remuneration level is reasonable and linked appropriately to the weight of the role based on accountability, job responsibilities and the knowledge and skills required for each of those positions.

Remuneration is set in accordance with NHS Agenda for Change for all staff other than doctors and directors. Pay and conditions of service for doctors is agreed nationally.

### Senior managers' remuneration policy

The remuneration package for senior managers consists of the following factors:

| Item | Rationale |
| --- | --- |
| **Salary** | Our strategy and business planning process set the key business objectives of our organisation which are delivered by the senior managers. This success measure is one of the ways in which the senior managers' performance is monitored.<br>Senior managers' remuneration is based on market rates and there are no automatic salary rises. To ensure that the pay and terms of service offered by the organisation are both reasonable and competitive, comparisons are made between the scale and scope of responsibilities of our senior managers and those of employees holding similar roles in other organisations.<br>A report is prepared for the Non-Executive Nominations and Remuneration Committee by the Chief People Officer, which makes these comparisons between our remuneration rates for senior managers and market rates.<br>The base salaries of Executive Directors in post at the start of the policy period and who remain in the same role throughout the policy period will not usually be increased by a higher percentage than the maximum incremental uplift applicable to the highest paid staff on Agenda for Change. The only exceptions are where an Executive Director has been appointed at below market level to reflect experience.<br>Senior managers are paid spot level salaries rather than on an incremental scale and may collectively receive an annual uplift in salary in line with '*Guidance on pay for very senior managers'* issued by NHSEI. |
| | All senior managers' remuneration is subject to satisfactory performance of duties in line with their employment.<br>There are no performance related pay so senior managers receive one hundred per cent of their salary subject to the relevant deductions. |
| **Taxable benefits** | The Non-Executive Nominations and Remuneration Committee agree any taxable benefit.<br>This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive.<br>There is no maximum amount payable. |
| **Pension** | Standard pension arrangements are in place in 2022/23.<br>This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive<br>There is no maximum amount payable. |
| **Bonus** | There is no bonus scheme for any senior manager, however bonus payments may be made on a discretionary basis subject to approval by the Non-Executive Nominations and Remuneration Committee.<br>All other staff, except the senior management team at Torbay Pharmaceuticals, are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally. |
| **Other** | Individual items such as lease cars are not offered as part of a remuneration package. Board level directors may, however, put forward an individual request in respect of such items.<br>Senior managers' terms and conditions e.g. holidays, pensions, sick pay are in accordance with Agenda for Change terms and conditions. |

### Senior manager’s objectives and performance

Senior managers meet annually with the Chief Executive to agree core and individual performance objectives and subsequently meet with the Chief Executive monthly to discuss the progress made towards the targets set. A formal interim progress review is held six months after the objectives are set, a final review of performance and achievement of objectives is held at the end of the year, when objectives for the following year are also discussed and agreed.

The Chief Executive’s performance is appraised using the same system, but their performance objectives are agreed with and monitored by the Chairman. This process was designed to ensure that clearly defined and measurable performance objectives are agreed, and progress towards these objectives is regularly and openly monitored, both formally and informally.

The Chief Executive presents an assurance report to the Committee each year outlining the appraisal process undertaken. The Committee also receives a summary report on the performance of each of the Executive Directors and Associate Directors and a recommendation in respect of any proposed changes to remuneration levels. The Chairman adheres to the same process in regard to the Chief Executive.

### Remuneration of Executive Directors and other employees

When setting remuneration levels for the Executive Directors, the Nominations and Remuneration Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other Foundation Trusts of a similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader organisational workforce.

In particular, the Nominations and Remuneration Committee considers the recommendations of the NHS Pay Review Body and the Review Body on Doctors’ and Dentists’ Remuneration as reflecting most closely the economic environment encountered by Executive Directors. We do not consult more widely with employees on such senior managers’ remuneration matters.

### Annual Report on remuneration

### Service contracts

The following table shows for each person who was an Executive or Associate Director or Non-Executive Director as at 31 March 2023, the commencement date for their current position and the term of service agreement or contract for services and details of notice periods.

| Director | Status | Contract start date | Contract term (years) | Unexpired term as at July 2023 | Notice period by the organisation | Notice period by the director |
|---|---|---|---|---|---|---|
| Mr I Currie | Executive Board member | 14.09.2020 | Indefinite terms | Not applicable | Three months | Three months |
| Ms L Davenport | Executive Board member | 01.10.2018 | Indefinite term | Not applicable | * | Six months |
| Mrs A Jones | Executive Board member | 22.07.2019 | Indefinite term | Not applicable | Three months | Three months |
| Ms D Kelly | Executive Board member | 01.08.2020 | Indefinite term | Not applicable | Three months | Three months |
| Mr J Scott** | Executive Board member | 18.10.2022 | 30.09.2023 | Not applicable | 24 hours | 24 hours |
| Mr D Stacey | Executive Board member | 06.01.2019 | Indefinite term | Not applicable | Three months | Three months |
| Dr J Watson | Executive Board member (non-voting) | 01.02.2020 | Indefinite term | Not applicable | Three months | Three months |
| Mrs E Long | Executive Board member & Trust Secretary (non-voting) | 01.11.2021 | Indefinite term | Not applicable | Three months | Three months |
| Dr M Westwood | Executive Board member | 27.11.2022 | Indefinite term | Not applicable | Three months | Three months |
| Sir Richard Ibbotson | Chairman & Non-Executive Board Member | 01.06.2021 | 1 year*** | 11 months | Three months | Three months |
| Mr C Balch | Non-Executive Board Member | 14.04.2022 | 3 years | 1 year and 8 months | Three months | Three months |
| Mrs J Lyttle | Non-Executive Board Member | 30.09.2020 | 1 year**** | 2 months | Three months | Three months |
| Mrs V Matthews | Non-Executive Board Member | 01.12.2020 | 3 years | 4 months | Three months | Three months |
| Mr P Richards | Non-Executive Board Member | 13.11.2020 | 3 years | 5 months | Three months | Three months |
| Mr R Sutton | Non-Executive Board Member | 01.05.2022 | 1 year ***** | 9 months | Three months | Three months |
| Mrs S Walker-McAllister | Non-Executive Board Member | 01.09.2022 | 3 years | 2 years and 2 months | Three months | Three months |
| Mr R Crompton | Non-Executive Board Member | 01.08.2022 | 3 years | 2 years and 1 month | Three months | Three months |
| Mr P Aitken | Associate Non-Executive Board Member (non-voting) | 01.01.2023 | 2 years | 1 year and 6 months | Three months | Three months |

Notes:
*as per statutory notice period i.e. one week for each year of employment up to a maximum of 12 weeks
** Mr J Scott is employed on an ongoing interim capacity on a bank contract of employment
***Sir Richard Ibbotson re-appointed for a fourth one-year term following two terms of office of three years
**** Mrs J Lyttle re-appointed for a third one-year term following two terms of office of three years.
***** Mr Sutton re-appointed for a second one-year term following two terms of office of three years
****** Mrs E Long, Maternity leave February 2022 – February 2023
Unless noted above, these officers have been in post throughout 2022/23

### Service contracts

As described above, senior managers contracts are open-ended (permanent) contracts. Non-Executive Directors serve terms of three years, up to a maximum of six years. The Council of Governors will consider and set terms of office for Non-Executive Directors beyond that point that meet the needs of the organisation, taking into account NHSE guidance and the NHS Code of Governance. Terms beyond that point should be set on an annual basis. Further details about the terms of office of each individual Non-Executive Director can be found in the Director's report within this annual report and accounts.

## Remuneration Committee Memberships and Meetings

Membership and details of meetings attendance can be found at page xx of this report.

We have established two Committees responsible for the remuneration, appointments and nominations of directors. A description of the Committee responsible for Non-Executive Director remuneration can be found in the section 'Committees of the Council of Governors'. The Committee responsible for the remuneration of Executive Directors is described below.

### The role of the Non-Executive Nominations and Remuneration Committee

The Non-Executive Nominations and Remuneration Committee ('the Committee') advises the Board on matters regarding the remuneration and terms of service for Executive Directors and senior managers. The Committee is established for the

purpose of overseeing the recruitment and selection process for Executive Directors and Associate Directors i.e. senior managers, and the appointment of formal Board positions, for example the Senior Independent Director. The Committee's second purpose is to determine the remuneration and terms of service of Executive Directors and Associate Directors.

The term 'senior managers' covers our employees in senior positions, who have authority and responsibility for directing and controlling major organisational activities. These employees influence the decisions of the entire organisation, meaning that the definition covers the Chief Executive and Board-level directors.

The advice offered covers all aspects of salary, including performance-related pay and bonuses, as applicable, pensions, provision of cars, insurance, and other benefits. Advice on arrangements for termination of contracts and other general contractual terms also falls within the remit of the Committee. Specifically, the Committee is charged with:

- advising on appropriate contracts of employment, including remuneration, for senior managers
- monitoring and evaluating the performance of individual senior managers
- making recommendations regarding the award of performance-related pay, based on both the organisation's performance and the performance of individuals
- advising on the proper calculation of any termination payments.

The Committee is empowered to obtain independent advice as it considers necessary. At all times, it must have regard to our performance and national arrangements for pay and terms of service for senior managers.

The Committee meets several times a year, to enable it to make its recommendations to the Board. It formally reports to the Board, explaining its recommendations and the basis for the decisions it makes.

The Committee's membership did not change during the year remained the Chairman, Vice-Chair, Senior Independent Director and the Chair of the People Committee. The Chief Executive and other senior managers should not be present when the Committee meets to discuss their individual remuneration and terms of service but may attend by invitation from the Committee to discuss other staff's terms. Accordingly, the Chief Executive and the Chief People Officer attend the Committee when required. The Trust Secretary attends the Committee in an advisory capacity.

### Chairman and Non-Executive Director remuneration

The Chairman's and Non-Executive Director's remuneration is overseen by the Governors' Nominations and Remuneration Committee ('Committee') as outlined in the Accountability Report 'Committees of the Council of Governors' section.

The Committee makes recommendations to the Council of Governors on the Non-Executive Directors and Chairman's remuneration levels, noting the NHSE guidance as published from time to time. The Chairman and Non-Executive Directors receive spot level remuneration but can claim reasonable expenses, for example travel expenses, as per other employees.

A review of remuneration levels applicable to Non-Executive Directors and the Chairman was undertaken during the year. The Committee was cognisant of the new remuneration framework and took the decision to maintain current levels of remuneration. Some Non-Executive Directors receive an additional one-off responsibility allowance based on Board positions held. No uplift in responsibility allowances was made during 2022/23.

The remuneration package for the Chairman and other Non-Executive Directors is made up of:

| Item | Rationale |
|---|---|
| **Remuneration** | £51,000 per annum for the Non-Executive Chairman - three days per week |
| **Remuneration** | £13,500 per annum for all other Non-Executive Directors - three days per month |
| **Remuneration** | Additional responsibility allowance of £3,000 for the Chair of the Audit Committee |
| **Remuneration** | Additional responsibility allowance of £1,500 given to the Senior Independent Director (SID) |
| **Remuneration** | Additional responsibility allowance of £1,000 given to the Vice Chair |
| **Expenses** | Chairman and Non-Executive Director mileage rates are aligned with latest guidance: 56p per mile for the first 3,500 miles reducing to 20p per mile thereafter. All other expenses remain in line with organisational policy. |

## Governors' expenses

Governors may be reimbursed for legitimate expenses, incurred during their official duties, as governors of the Torbay and South Devon NHS Foundation Trust.

During the financial year, Governors were paid expenses to reimburse costs incurred while attending meetings of the Foundation Trust and at external training and development events.

| | 31 March 2022 | 31 March 2023 |
|---|---|---|
| Number of Governors in office | 26 | 31 |
| Number of Governors receiving expenses | 1 | 3 |
| Total expenses paid to Governors | £18.00 | £260.20 |

Note: Due to the COVID-19 pandemic very few face to face meetings were held in 2021/22, hence the unusually low level of expenses paid to governors in that year.

## Fair pay multiple (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in Torbay and South Devon NHS Foundation Trust in the financial year 2022/23 was £360,000 - £365,000 (2021/22, £210,000 - £215,000). This was 10.9 times (2021/22, 6.8) the median remuneration of the workforce, which was £32,919 (2021/22, £31,534).

The increase in ratio from 6.8 to 10.9 in 2022/23, is due to a change in highest paid director and a salary increase in comparison to the previous highest paid director in 2021/22. The current highest paid director is the Interim Chief Operating Officer who is employed on a fixed term contract to fill a short notice vacancy. The Trust has required to temporarily extend this contract following an unsuccessful first recruitment round.

In 2022/23, 0 (2021/22, 3) employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £20,270 to £360,000 (2021/22, £18,546 - £262,188).

Total remuneration includes salary and non-consolidated performance-related pay. It does not include benefits-in-kind, severance payments, employer pension contributions and cash equivalent transfer value of pensions.

The median calculation is based on the full-time equivalent staff of the Foundation Trust at the reporting period end date on an annualised basis.

### Fair pay multiple (audited information) – 25th and 75th Percentile

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2022/23 was £360,000 - £365,000 (2021/22, £210,000 - £215,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the table overleaf.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the trust as a whole, remuneration ranged from £20,270 to £360,000 in 2022/23 (2021/22, £18,546 to £262,188).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2%.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

| | 2022/23 | | | 2021/22 | | |
|---|---|---|---|---|---|---|
| | 25th Percentile | Median | 75th Percentile | 25th Percentile | Median | 75th Percentile |
| Salary component of pay | £23,177 | £32,919 | £41,659 | £21,777 | £31,534 | £39,042 |
| Total pay and benefits excluding pension | £23,177 | £32,919 | £41,659 | £21,777 | £31,534 | £39,042 |
| Total pay and benefits excluding pension: pay ratio for highest paid director | 15.5:1 | 10.9:1 | 8.6:1 | 9.8:1 | 6.7:1 | 5.4:1 |

## Definition of 'senior managers'

The definition of 'senior managers' is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. This includes the Chief Executive, Chairman, Executive, Associate and Non-Executive Directors. This definition covers all those who hold or have held office as Chairman, Non-Executive Director, Executive Director, or Associate Director of the organisation during the reporting year. It is irrelevant that:

- an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment)
- an individual's title as director included a prefix such as 'interim, acting, temporary or alternate'
- an individual was engaged via a corporate body, such as an agency, and payments were made to that corporate body rather than to the individual directly.

### Policy on payment for loss of office for senior managers

Senior managers are employed on substantive contracts of employment and are employees of the organisation. Their contracts are open-ended employment contracts which can be terminated by either party by giving notice in accordance with their individual service contract.

Our normal disciplinary policy applies to senior managers, including the sanction of instant dismissal for gross misconduct. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

This concludes the Renumeration Report for 2022/2023.

Liz Davenport
Chief Executive
28 June 2023

## PART IV – Staff report

### Analysis of staff costs (audited information)

The Foundation Trust is required to provide an analysis of staff costs, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other staff'.

| | 2022/23 | | | 2021/22 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently employed | Other | Total | Permanently employed | Other |
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Salaries and wages | 263,711 | 263,257 | 454 | 232,433 | 231,436 | 997 |
| Social security costs | 24,679 | 24,679 | - | 21,588 | 21,588 | - |
| Apprenticeship levy | 1,208 | 1,208 | - | 1,125 | 1,125 | - |
| Employer's contributions to NHS pensions | 29,588 | 29,588 | - | 27,827 | 27,827 | - |
| Pension cost – Employer contributions paid by NHSE/ NHSI on Trust's behalf (6.3%) | 12,985 | 12,985 | - | 12,199 | 12,199 | - |
| Pension cost - other | 59 | 59 | - | 50 | 50 | - |
| Temporary staff | 14,513 | - | 14,513 | 13,247 | - | 13,247 |
| **Total staff costs** | **346,743** | **331,776** | **14,967** | **308,469** | **294,225** | **14,244** |
| Of which: Costs capitalised as part of assets | 3,373 | 3,373 | - | 2,608 | 2,608 | - |

We incurred £376,000 (2021/22 £85,000) in respect of other post-employment benefits, other employment benefits, or termination benefits. We did not second any staff in either year to other organisations, instead where staff were supplied to other organisations we generated an income from this service.

### Analysis of worked full time equivalents (FTEs) (audited information)

We are required to provide an analysis of average staff numbers, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other' staff.

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating whole time equivalent number is used, that is, dividing the contracted hours of each employee by the standard working hours. Staff on outward secondment are not included in the average number of employees.

| NHSI Staff Group | 2022/23 | | | 2021/22 |
|---|---|---|---|---|
| | **Total** | *Of which permanently employed* | *Of which other* | **Total** |
| Allied Health Professionals | **517** | *506* | *11* | **523** |
| Health Care Scientists | **93** | *92* | *1* | **93** |
| Medical and Dental | **566** | *1,115* | *47* | **574** |
| NHS Infrastructure Support | **1,162** | *273* | *293* | **1,151** |
| Other Scientific, Therapeutic and Technical Staff | **345** | *327* | *18* | **348** |
| Registered Ambulance Service Staff | **11** | *11* | *0* | **10** |
| Registered Nursing, Midwifery and Health Visiting Staff | **1,348** | *1,318* | *31* | **1,292** |
| Support to Clinical Staff | **1,973** | *1,840* | *133* | **1,897** |
| **Total** | **6,016** | ***5,482*** | ***534*** | **5,887** |

** Figures as at 03 April 2023*

## Analysis of sickness absence

We continue to develop the overall health and wellbeing of our people and our management of sickness absence. The sickness absence rate for 2022/23 compared to the previous five years is shown below. As was the case in the previous financial year, absence related to COVID-19 was a key contributor to the levels of sickness witnessed in the year.

| Year | 12 month sickness | Average FTE | FTE days available | FTE days lost to sickness | Average sickness absence duration (FTE days) |
|---|---|---|---|---|---|
| 2017/18 | 4.09% | 5,163 | 1,884,585 | 77,054 | 9.2 |
| 2018/19 | 4.23% | 5,177 | 1,889,505 | 79,859 | 9.5 |
| 2019/20 | 4.45% | 5,410 | 1,974,776 | 87,942 | 10.0 |
| 2020/21 | 4.02% | 5,667 | 2,068,557 | 83,152 | 9.0 |
| 2021/22 | 5.02% | 5,806 | 2,119,241 | 106,286 | 11.3 |
| 2022/23 | 5.27% | 6,027 | 2,199,716 | 115,864 | 11.9 |

Note: Source: from the Electronic Staff Record (ESR)

- period covered: April 2022 to March 2023 (Data as at 03 April 2023)
- data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year
- the number of Full-Time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to an average FTE in the third column by dividing by 365
- the number of FTE days lost to sickness absence has been taken directly from ESR
- the average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

## Analysis of staff turnover

Information showing our staff turnover data can be accessed via the following link to the NHS Digital website NHS workforce statistics - NHS Digital

## Staff policies and actions applied during the year

We continue to be committed to providing an inclusive environment for our patients, staff and visitors. We believe in providing equity in our services, in treating people fairly with respect and dignity and in valuing diversity both as a health and care services provider and as an employer.

Our diversity and inclusion policy set out the responsibilities of the organisation, our staff and people who use our services. We actively promote a culture that values difference and recognises that people from different backgrounds and experiences bring valuable knowledge and insights to the workplace and enhances the way we work. We strive to be inclusive, to value, respect and embed diversity in all areas across the organisation. This will support us to recruit and retain a diverse workforce that reflects the communities we serve. Our diversity and inclusion policy afford equal protection to those who access our services, ensuring people are involved in their care and our workforce, ensuring our people have fair and equal opportunity.

We are committed to compliance with the Equality Act 2010, and as part of the subsequent Public Sector Equality Duty, we are dedicated to:

- eliminating discrimination
- promoting equality of opportunity
- fostering good relations.

All our policies continue to be subject to a rapid or full (E) quality impact assessment which aims to tackle discrimination or disadvantage at the outset.

Employability activity supports those who may experience disadvantage to find sustainable employment through experience-based work placements. We support a range of people to develop their employability skills in a safe environment through our work experience programmes, traineeships if appropriate, apprenticeships and eventually through securing employment. We have created a stronger local network with the voluntary sector and DWP to work together on improving access to employment.

We have also joined the disability confident initiative (this replaced the √√ (2 ticks) scheme) and we are a disability committed employer who aims to progress to level two disability confident status in 2023/24

One in three of our people are unpaid carers (source: National Staff Survey 2022) and during this year, we have enhanced our support for staff who are juggling working with caring for a family member or friend. It is now firmly embedded within wellbeing with our wellbeing buddies receiving training in carer awareness. Access to support has been made simpler and managers who support staff carers have recently been recognised at our annual our people celebration event..

We continue to be a ‘Mindful Employer’, supporting health and wellbeing at work and this work continues to be reflected within our people promise. The plan is reflective of the national priorities, integrated care system (ICS) and organisational priorities. During the year our health and wellbeing programmes have focused on:

- successfully delivering our winter COVID and Flu vaccination programme and delivering the spring booster COVID programme
- we have been allocated monies via Charities Together to support our people's wellbeing specifically for:
- mental health training for managers. We worked with a local charity to provide the training both face to face and via MS Teams
- the development and support of our wellbeing buddy community including mental health first aider training. We currently have 250 wellbeing buddies
- focused wellbeing activities for specific staff groups to support their mental health
- our dedicated wellbeing week which focused on ‘looking after me’
- in line with our developing just and learning culture we reviewed and updated the following policies:
- wellbeing at work
- mental health and wellbeing
- domestic abuse
- misuse of alcohol and substances
- establishing a cost of living group which works closely with other key stakeholders eg Torbay Council to understand the impact on our people and actions to support
- undertaking a review of wellbeing using the National Health and Wellbeing Framework diagnostic tool in conjunction with our people promise and EDS2 to identify our priorities for 2023/24.

We recognise that there may be times when our people experience episodes of poor health and wellbeing and this is reflected in our National Staff Survey results. We have policies in place to ensure our people

get the support and guidance and reasonable adjustments they need to assist them through this difficult time. Our occupational health service is focused on the safety, health and wellbeing of our staff, patients and visitors.

We offer a full range of occupational health services, which are available to all our people including the following:

- health promotion as well as health information and advice
- health surveillance for employees identified as ‘at risk
- workplace assessments
- immunisation programmes
- training and policy advice
- infection control including ‘needlestick hotline’
- baseline screening for new employees.

We have recently commissioned a new Employee Assistance Programme (EAP) that staff can access themselves for a range of issues they may wish to seek support for, including physical and mental health as well as financial wellbeing. We advertise and promote this service widely to our people.

Our corporate health and safety team moved into our Workplace Team (formerly known as estates and facilities management). In conjunction with our Health and Safety Committee and with other relevant stakeholders and teams, our corporate health and safety team continue to develop a cultural improvement plan for organisational safety which focusses on training, individual accountability and improved reporting of hazards. In that spirit, additional learning is being rolled out

across the organisation in the form of Institute of Safety and Health (IOSH) Managing Safely training for all line managers. National Examination Board in Occupational Safety and Health (NEBOS) environmental training has also been provided to key people across our services to enhance our environmental safety focus.

We manage health and safety through a series of steering groups and committees which are attended by clinical and non-clinical colleagues, as well as relevant external consultants and regulators. These include the health and safety committee, the fire safety group, the asbestos safety group and the water safety group.

The anonymous digital communication platform Work In Confidence has been launched by our Freedom to Speak Up Guardian to give staff an alternative route to Speak Up. This enables our people to have a conversation with the Guardian without identifying themselves, this is proving successful and is being used both by individuals and teams. The platform is also being used to undertake anonymous surveys where concerns have been raised. This gives a temperature check and an opportunity for sharing experiences confidentially. The survey results are then shared with line managers to develop an appropriate action plan to help resolve the concerns, Proactive work to raise awareness through film, interactive platforms and face to face sessions continues as well as reactive work supporting both staff and managers in resolving concerns. The new national Freedom to Speak Up Policy will be launched alongside the new Patient Safety Incident Response Framework later in 2023.

Our Equality Business Forum (EBF) continues to provide the leadership for our network groups which include our disability network and our lesbian, gay, bisexual and transgender group (LGBTQ+). In addition to further reflect the diversity and needs of our people we also have an under 30s network, a menopause group, and a mental health group. Our BAME engagement group has significantly grown and now has more than 100 members. In addition, we have active representatives on the Devon-wide BAME network. Our EDI Lead in their capacity of system BAME network chair has presented to the Devon ICB Board sharing the experiences of our newly recruited international nurses. Our network chairs attend our People Committee, which is a sub committee of our Board of Directors, to raise awareness of issues affecting their members and provide assurance around how these are being addressed.

Whenever possible we continue to have an inclusivity representative on interview panels to ensure recruitment processes are inclusive. This also ensures we are growing a more inclusive and diverse future workforce and enabling the career progression for people from minority groups.

Through our evolving people promise plan, we have undertaken significant engagement with people from under-represented groups in order to better understand what is needed to ensure a culture of inclusion and belonging. The themes identified from this work together with the results of the staff survey have informed our work for 2022/23; these included:

- the menopause network chair invites guest speakers who have specialist knowledge in the menopause to provide updates, raise awareness of symptoms and advice of what is available to support anyone going through the peri-menopause and are in menopause
- we are now providing training for a menopause mentor

- we are developing training about the peri-menopause and menopause for managers
- we promote and raise awareness of Ramadan, Diwali and other celebrations through articles, videos and offering diverse foods in our staff canteen
- we raised awareness through disability history month however unfortunately due to industrial action we had to postpone our planned disability conference
- we celebrated a highly successful Black History Month the highlight of which was a series of workshops with a national speaker. The workshops highlighted the journey of the NHS and the historic policies and procedures that it has inherited and the impact it has on us all now
- our overseas colleagues hosted a cultural event that included dancing, music, drumming and poetry and international foods
- we raised awareness of race equality through daily challenges on key topics designed stimulate personal reflection own bias and privilege
- 29 of our people completed our inaugural BME Leadership programme with several achieving promotion during this time
- We started to develop and co-design a training framework for managers to raise cultural awareness to ensure smooth the transition for international colleagues into their new team. Our international colleagues have been pivotal in designing this with us.

## 2023 national NHS staff survey

### Staff engagement and experience

We know that the best way to care for people who use our services is to care for the people who deliver those services – our dedicated, talented, compassionate staff. Supporting them to live well is central to enabling us to deliver our purpose – to support the people of Torbay and South Devon to live well.

Research evidences a clear relationship between people feeling seen, heard and valued and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality and safety measures, including infection rates.

The better we support and listen to our people, the better the outcomes and experience for people who use our services.

We have a range of well-established forums for our people to share their views and to engage with us including:

- Trust Talk – monthly briefing session from the Executive Team which is livestreamed, with opportunities for question and answers
- 'Just Ask!' noticeboard for people to ask questions or raise issues with the Executive Team
- staff surveys including the national annual staff survey and quarterly people pulse
- bespoke forums including the mental health forum and menopause group
- Freedom to Speak Up Guardian and champion network
- equality business forum and staff network groups
- joint consultations/negotiations with the Trade Unions
- wellbeing buddies
- staff governors.

## NHS staff survey

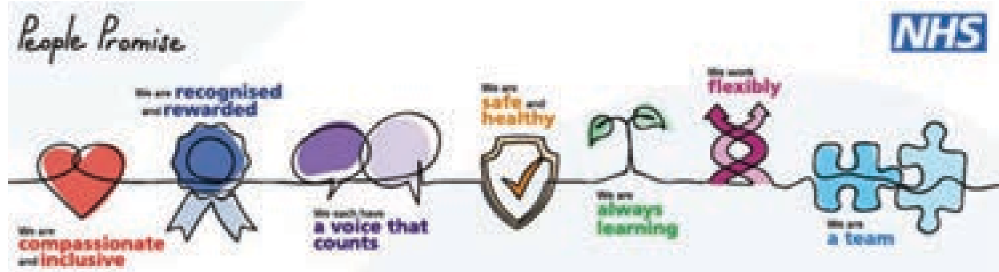
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The past 12 months has continued to challenge each and every one of our teams as we try to deliver better health and care for all and ensure that people waiting for care and treatment can be seen as quickly as possible.

The annual staff survey provides an incredibly helpful insight into the experience of our people at work. The survey is aligned to the NHS people promise which is based on what our people say matter to them most. As such, the survey feedback is presented in the form of nine elements – the seven people promises, together with two additional elements- staff engagement and staff morale. Each element receives a score from 0 to 10, with 10 being the best score attainable.

Regrettably, we saw a reduction in the overall response rate from 42% in 2021 to 38% in 2022. This compares to a median response rate of 44% for our benchmarking group - acute and acute and community trusts.

The feedback is presented below, together with the three previous reporting periods.




### 2022/23 and 2021/22

| Elements | Foundation trust 2022 | Benchmarking group | Foundation trust 2021 | Benchmarking group |
|---|---|---|---|---|
| We are compassionate and Inclusive | 7.2 | 7.2 | 7.2 | 7.2 |
| We are recognised and rewarded | 5.8 | 5.7 | 5.9 | 5.8 |
| We each have a voice that counts | 6.6 | 6.6 | 6.7 | 6.7 |
| We are safe and healthy | 5.8 | 5.9 | 5.9 | 5.9 |
| We are always learning | 5.2 | 5.4 | 5.1 | 5.2 |
| We work flexibly | 6.1 | 6.0 | 6.1 | 5.9 |
| We are a team | 6.7 | 6.6 | 6.7 | 6.6 |
| Staff engagement | 6.7 | 6.8 | 6.8 | 6.8 |
| Morale | 5.6 | 5.7 | 5.8 | 5.7 |

### 2020/21 and 2019/2020 – new reporting categories as of 2020/21

| | Foundation trust 2020/21 | Benchmarking group | Foundation trust 2019/20 | Benchmarking group |
|---|---|---|---|---|
| Equality, diversity and inclusion | 9.2 | 9.1 | 9.2 | 9.2 |
| Health and wellbeing | 6.1 | 6.1 | 6.1 | 6.0 |
| Immediate managers | 6.9 | 6.8 | 6.9 | 6.9 |
| Morale | 6.4 | 6.2 | 6.3 | 6.2 |
| Quality of appraisals | *Theme removed from reporting* | | 5.1 | 5.5 |
| Quality of care | 7.3 | 7.5 | 7.3 | 7.5 |
| Safe environment – bullying and harassment | 8.1 | 8.1 | 8.2 | 8.2 |
| Safe environment – violence | 9.5 | 9.5 | 9.5 | 9.5 |
| Safety culture | 6.6 | 6.8 | 6.6 | 6.8 |
| Staff engagement | 7.0 | 7.0 | 7.0 | 7.1 |
| Team working | 6.5 | 6.5 | 6.6 | 6.7 |

In comparison to last year, the feedback demonstrates that we have maintained or improved our performance in four of the nine elements: we are compassionate and inclusive, we are flexible, we are a team, we are always learning. It's important that we are all able to learn and flourish in our roles and we have seen the biggest improvement in our appraisal feedback. We have also seen an improvement in our flexible working feedback, which is hugely positive as we know this is a key reason why people choose to continue working with us.

We have, however, seen a statistically significant lower performance in staff engagement, staff morale, we are safe and healthy and we are recognised and rewarded. The pressure our people feel at work is an area of concern as many have told us they do not feel there are not enough people available to do their job well.

### Future priorities

The people element of our regain and renew plan (our people promise) seeks to respond directly to the feedback from the survey by identifying two clear priorities:

- We will make our people lives easier and free up time to work in a safe and calm way on agreed priorities. We will seek to do this by improving our workforce processes, such as reducing the time it takes to hire new people and rolling out e-rostering across our services. We will develop our approach to long term workforce planning and the development of career pathways so that we can grow our own future workforce – recognising the immense skills and talents of our people. We will continue our focus on retention and improving those areas that are most important to our people.
- We will also define and deliver a consistent, compassionate and inclusive leadership and management approach - ensuring that our managers and leaders feel valued and supported, have reasonable spans of control so workload is manageable, as well as the skills and confidence to lead effectively in these very challenging times.

Performance against our people plan is monitored through our People and Education Governance Group and ultimately the People Committee as a sub- committee of our Board of Directors.

## Diversity and inclusion

Diversity and Inclusion is at the forefront of everything we do within the NHS. We are committed to building an organisation that puts people's wishes at the centre and removing the barriers that hinder staff and prevent them working to their full potential.

Our values are the NHS values and we embed these through our recruitment and appraisal processes.. In addition, our people promise leadslead the way in which we treat all people whether a member of staff or the public. Our people can be assured that they will continue to be supported and valued to carry out their duties effectively, ensuring that everyone counts.

Our equality, diversity and inclusion programme of work is integral to the delivery of our people promise and is key to improving the experience of our people who are part of under-represented groups.

We developed our priorities for the programme through in-depth engagement with our people. These include:

- a relentless focus on addressing bullying and harassment through:
- raising the profile of unacceptable behaviour and addressing by holding people to account, providing support and further development for staff
- training managers to be confident in addressing poor behaviours through our new leadership and management training package
- raising cultural awareness through education, personal reflection and modernised, meaningful mandatory training for all staff
- developing career pathways and supporting career progression has been predominantly focused on BME staff during this year. We recognise through our staff survey this needs to other groups of under-represented staff in particular those with a long-term condition or disability. A scheme of actions are being developed.
- strengthening and developing our networks to be even more influential and driving change for under-represented people remains to be a priority for 2023/24.

## Workforce Disability Equality Standards (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

## Making a difference for disabled staff

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Nine of the 13 WDES indicators are taken from the National Staff Survey. The table below shows our performance against the WDES standards and the actions taken in 2022/23 to address the position. Regrettably, despite the action taken the feedback indicates an overall decline in experience for our people with a long-term condition

(LTC), in comparison to our people without LTC that remains largely unchanged. The only indicators that are showing a degree of improvement are equal opportunities for career progression, reporting of bullying, harassment and aggression (BHA) and the marginal reduction in BHA from patient and service users

| | LTC or illness 2021 | Without LTC 2021 | LTC or illness 2022 | Without LTC 2022 | LTC or illness average 2022 |
|---|---|---|---|---|---|
| % staff experiencing BHA from patients, relatives or public | 32.1% | 25.4% | 31.9% | 25.3% | 32.4% |
| % staff experiencing BHA from manager | 16.3% | 8.7% | 18.7% | 8.6% | 17.1% |
| % staff experiencing BHA from colleagues | 24.5% | 15.9% | 29.2% | 15.7% | 26.9% |
| % of staff that reported experience of BHA | 48% | 48.6% | 49.8% | 48.4% | 48.4% |
| % staff believing equal opportunities for career progression | 49.7% | 59% | 50.8% | 58.8% | 51.4% |
| % staff feeling pressure from manager to come to work despite feeling unwell | 25.1% | 19.8% | 29.8% | 19.9% | 32.2% |
| % staff satisfied with the extent we value their work | 34% | 40.8% | 31.1% | 41.6% | 32.5% |
| % staff saying we have made adequate adjustments for them to carry out work | 76.3% | | 71.8% | | |
| Staff engagement score (0-10) | 6.4 | 6.9 | 6.3 | 6.8 | 6.4 |

### Actions undertaken in 2022/23

- anti-bullying advisors network available to provide a safe space and support for staff. A review and evaluation of this service has commenced to improve uptake, visibility and diversity of group
- reasonable adjustment information refreshed, promoted through health and wellbeing and employee relations team and continues to be available on the EDI web pages
- a team of mediators are available and have commenced promotion of their service and developing a stronger partnership.

To further address and see improvement in 2023/24 these are the actions that will be taken:

- following review and evaluation of anti-bullying advisor service co-design the programme of work to reduce BHA with members of EDI networks
- commencement of a programme of work focusing on a ‘Just and Learning Culture’. This will be designed to move our focus and practice of looking back at the harm done and the often-punitive consequences to one that seeks to understand what has happened focusing on the future and the trust that needs to be repaired and investment in relationships
- proactive focus on bullying and harassment to include raising awareness of incivility, personal attitude and behaviour impact on others
- further raising awareness of mediation network to provide proactive support and early intervention with managers. Training will be provided for managers through the new leadership and management training package

- understanding barriers to career progression for people through our Disability Network and staff workshops
- renewed focus on our Disability Network to increase membership and diversity of people living with LTC
- recruit disability inclusivity representatives to be part in interview panels ensuring inclusive recruitment practices
- raise awareness of reasonable adjustment options and embed practice through task and finish group.

## Workforce Race Equality System

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations.

The WRES was introduced in 2015 to hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between our black and minority ethnic (BME) and white staff.

Four of the nine WRES indicators are taken from the National Staff Survey and these are the actions

The table below shows our performance against the WRES standard for the last two years and in comparison, to the national average. The broad headlines are: experience of bullying, harassment and abuse (BHA) from patients has remained consistent for white staff but has increased by over 3% for our BME staff which is significantly higher than the national average and must be an area of focus this year worryingly, BHA from staff toward our BME staff has increased by over 7%, whilst remaining consistent for white staff. Again, this is significantly higher than the national average and must be an area of focus this year the percentage of staff feeling there are equal opportunities for career progression has remained largely consistent for both demographic groups and significantly higher than the national average the prevalence of discrimination has also increased at a higher rate for our BME staff which is now above the national average and widens the disparity gap further. Engagement work to understand the nature and form discrimination is planned to ensure appropriate actions are developed but will be central to the redevelopment of our training and education around compassion and inclusion incorporating how we lead inclusively, and civility and respect.

| | BME 2021 | White 2021 | BME 2022 | White 2022 | BME Average 2022 |
|---|---|---|---|---|---|
| % staff experiencing BHA from patients, relatives or public | 33% | 26.5% | 36.2% | 26.4% | 30.8% |
| % staff experiencing BHA from staff | 24.6% | 22.3% | 31.8% | 22.9% | 28.8% |
| % staff believing equal opportunities for career progression | 51% | 57.3% | 51.7% | 57.1% | 47% |
| % staff experiencing discrimination at work from manager or colleagues | 17.3% | 6.3% | 18.6% | 6.9% | 17.3% |

The actions undertaken during 2022/23 to improve the experience of our BME staff included:

- in partnership with the clinical safety team we have reviewed the policies, guidance, systems and processes that address the rise in racist behaviour and language. This has included focused support for members of staff after such an incident
- we launched our inaugural BME Leadership programme where 29 BME members of staff completed and graduated. This was designed to increase personal and collective confidence in order to enable individuals to realise and reach their potential as inclusive leaders
- we have continued to support our BME network and staff to send out key messages within the organisation
- in collaboration with international staff designed a training package for managers to support the improvement of the integration and transition into the workplace for new international team members
- our EDI Lead, also the system BME network chair presented to the Integrated Care Board, sharing the experiences of international nurses as they integrate into their new workplace. The purpose being to improve their experience now and for future international nurses coming to Devon.

Despite these actions there is still further improvement to be made during 2023/24 and these include:

- commencement of a programme of work focusing on a ‘Just and Learning Culture’. This will be designed to move our focus and practice of looking back at the harm done and the often punitive consequences to one that seeks to understand what has happened focusing on the future and the trust that needs to be repaired and investment in relationships
- engagement with staff networks and wider forums to understand the nature and forms of bullying, harassment and discrimination. The findings will inform the development included in our training package for managers and wider organisation relating to compassion
- following review and evaluation of anti-bullying advisor service co-design the programme of work to reduce BHA. This will be done in collaboration with our EDI networks and will be informed by the point above
- commit with deliberate intent to an organisationalanti-racism charter that sets out a zero-tolerance position together with a campaign of raising awareness of unacceptable behaviours and support to educate and develop people when this occurs
- complete and launch of modernised mandatory training deigned to cause staff to reflect on their own behaviours and language towards others
- supporting career progression with the launch of a second BME Leadership programme.

### Actions undertaken

- vlogs were delivered by our Chief Executive at the beginning, during and end of Ramadan
- our BME EDI Lead is a vaccine ambassador and was interviewed by a local TV broadcaster to encourage the uptake of the vaccine

- we have worked alongside our international nurses' team, to improve the experience of our BME nurses and to monitor their journey within the organisation
- a bullying and harassment project has been advertised and the training of advisors has taken place
- our Board of Directors participated in a facilitated development session discussing equality, diversity and inclusion and what this means strategically and their leadership role for the organisation.

### Next steps

- continue to grow our BME network to provide a safe space for our people's voices to be heard, to share experiences, offer peer support and have a sense of belonging
- ensure we have a rolling programme of events and spaces to increase confidence and trust of our staff. Encourage our BME staff to lead and take part in celebrating diversity and inclusion across the organisation
- implement listening events to hear the first-hand the experiences of our staff. Workshops are underway to gain insight and better understand barriers to career progression. Encourage members to share their stories safely.
- continue working with our communities to reach those we seldom hear from
- launch our managers essential training programme to raise awareness of bullying and harassment experiences, unconscious bias and the need for managers to be culturally competent and compassionate leadership training for managers to help support themselves and staff
- progress work to create an inclusive culture throughout the organisation through promoting self-awareness and ensuring recruitment processes are diverse and inclusive
- review our recruitment processes to support the recruitment of an inclusive and diverse workforce
- develop a range of resources for leaders and staff to engage in meaningful conversations around race and inequality
- address the lack of BME staff in Band 8A and above posts. Introduce Inclusivity reps on interview panels. Explore bespoke recruitment agencies and target recruitment and retention
- recruit members of BME staff to our Anti-Bullying Network. Campaign to encourage BME staff to join with support of the BME Network chair and the executives
- embark on a reciprocal mentoring programme with an emphasis on race
- promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, identifying any specific gaps requiring some targeted or bespoke programmes
- Continue to offer bespoke coaching programme for BME staff as part of our development offer
- modernise the EDI mandatory training for all staff raising awareness and educating everyone on EDI matters and personal impact on others.

## Gender pay differential

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The data in this report is based on snapshot taken on 31 March 2022.

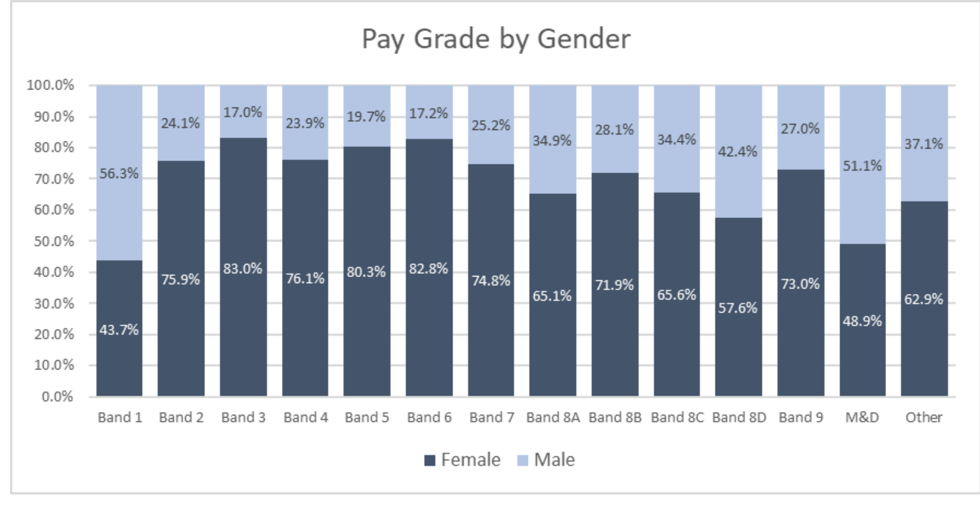
An analysis of the Foundation Trust workforce as at 31 March 2022, split by directors, Band 8A and above and all employees, is shown below:

| | Male % | Male headcount | Female % | Female headcount |
|---|---|---|---|---|
| Executive Directors | 57.1% | 4 | 42.9% | 3 |
| Band 8A and above | 31.0% | 95 | 69.0% | 211 |
| Employees | 21.83% | 1659 | 78.17% | 5940 |

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap analysis below shows the difference in the average pay between all men and women in a workforce. Generally, the average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. While a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower.

The current gender split within the overall workforce is 78.17% female and 21.83% male. The breakdown of proportion of females and males in each banding is as follows:



## Average gender pay gap

### Average gender pay gap as mean average (All applicable Foundation Trust staff)

| | Male | Female | % difference |
|---|---|---|---|
| Mean hourly rate 2018 | £18.76 | £14.85 | 20.84% |
| Mean hourly rate 2019 | £18.89 | £15.22 | 19.44% |
| Mean hourly rate 2020 | £19.51 | £15.72 | 19.41% |
| Mean hourly rate 2021 | £19.58 | £16.07 | 17.89% |
| **Mean hourly rate 2022** | **£20.62** | **£16.79** | **18.54%** |

### Average gender pay gap as median average (all applicable Foundation Trust staff)

| | Male | Female | % difference |
|---|---|---|---|
| Median hourly rate 2018 | £14.16 | £13.10 | 7.49% |
| Median hourly rate 2019 | £14.21 | £13.29 | 6.49% |
| Median Hourly rate 2020 | £14.73 | £13.83 | 6.09% |
| Median Hourly rate 2021 | £14.58 | £14.02 | 3.83% |
| **Median Hourly rate 2022** | **£16.12** | **£14.92** | **7.43%** |

### Summary of results average gender pay gap

The overall percentage variance for the average hourly rate of pay as a mean average is low at 18.54% and this has increased from last year which was 17.89%. This calculation is based on the average hourly rate of 5940 female staff compared to 1659 male staff; because the average is calculated over different numbers of staff (there are almost four times more female staff), some variance is to be expected.

The percentage variance for the median hourly rate of pay is 7.43%. This calculation is based on the average hourly rate at the mid-point for each gender group. This can be more indicative than the average hourly rate of pay as it is not impacted much by the female to male ratio.

However further investigation has shown that when medical and dental staff are removed from the calculations then the gender pay gap is in favour of female staff. It is the inclusion of our consultant body which shows to have a significant impact on the figures, as the majority of our senior consultants are predominantly male (148 male to 104 female consultants) and have a significant number of years seniority.

This impact can be seen on the mean hourly rate supporting the theory that medical and dental staff do influence the hourly rate which has risen to 13.04% after a 3-year reduction trend from 2019-2021. Male medical and dental staff have seen a 4% rise in their mean hourly rate in comparison to females who have seen a 3% average rise. This is comparable with the agenda for change staff who show male colleagues increase at 6% with their female colleagues at 5%. This can be related to the 60/40 split in male to female ratio for consultants.

- Having reviewed the data there are two themes which stand out: when looking at the total workforce, male staff are disproportionately represented in the lowest and highest pay quartiles
- the most obvious imbalance of pay is among the medical and dental staff, namely with regards to the historic CEA Bonus pay.

It is the inclusion of our consultant body which shows a significant impact on the figures, reversing the female positive gender pay gap across the remainder of our workforce.

Analysis of our medical workforce continues to reveal its own complexities. The junior doctors show a pay gap in favour of female staff, but at more senior level then this is in favour of male employees, with a higher number of male consultants employed compared to female. The legacy of a predominantly male consultant body is slowly changing, as demonstrated by the current junior doctor workforce, which shows a higher number of female employees compared to male.

Additional information on our latest published Gender Pay Gap Report can be found on the website at [Equality and Diversity - Torbay and South Devon NHS Foundation Trust] and at the Cabinet Office website at [Torbay And Southern Devon Health And Care NHS Trust gender pay gap data for 2020-21 reporting year - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)]

| Relevant union officials | |
|---|---|
| Number of employees who were relevant union officials during the relevant period | 1 |
| Full-time equivalent employee number | 1 |

Percentage of time spent on facility time

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1 – 50% | 0 |
| 51% - 99% | 0 |
| 100% | 1 |

| Percentage of pay bill spent on facility time | |
|---|---|
| Total cost of facility time | £67.617.19 |
| Total pay costs | £303,439,016.38 |
| Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time divided by total pay bill) x 100 | 0.022% |

| Paid trade union activities | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on trade union activities by relevant union officials during the relevant period + total paid facility time hours) x 100 | 100.00% |

## Consultancy costs

Expenditure on consultancy costs for 2022/23 was £936,000 compared with £362,000 for 2021/22.

## Off-payroll report

PES (2018)13 requires the Foundation Trust to seek assurance from individuals working through off-payroll engagements, that all their tax obligations are being met. This is required for existing and new engagements that during the period between 1 April 2022 and 31 March 2023 cost more than £245 per day and were engaged for more than six months.

The Foundation Trust is required under the reporting requirements published by HM Treasury in relation to PES (2018)13, to report if it had any engagements which met the disclosure requirements. The Foundation Trust can confirm that it had no engagements requiring disclosure.

## Off-payroll worker engagements as at 31 March 2023

| **Number of existing engagements as of 31 March 2023** | 4 |
|---|---|
| Of which………. | |
| Number that have existed for less than one year at time of reporting | 0 |
| Number that have existed for between one and two years at time of reporting | 0 |
| Number that have existed for between two years and three years at time of reporting | 2 |
| Number that have existed for between three and four years at time of reporting | 0 |
| Number that have existed for four or more years at time of reporting | 2 |

## All off-payroll workers engaged at any point during the year ended 31 March 2023

| **Number of off-payroll workers engaged during the year ended 31 March 2023** | 5 |
|---|---|
| Of which………. | |
| Number assessed as within the scope of IR35 | 0 |
| Number assessed as not within the scope of IR35 | 5 |
| Number of engagements reassessed for consistency/assurance purposes during the year | 1 |
| Of which: Number of engagements that saw a change to IR35 status following review | 0 |

## For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023

| Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year | 0 |
|---|---|
| Number of individuals that have been deemed 'Board members and/or senior officials with significant responsibility' during the financial year. This figure must include both off-payroll and on- payroll engagements | 20 |

Note: The Foundation Trust has a number of doctors who meet the financial criteria but have no significant financial responsibility and therefore fall outside of the scope of the reporting requirement.

## **Staff exit packages paid in year (audited information)**

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

| Exit package cost band (including any special payment element) | Compulsory redundancies | | Other departures agreed | | Total of exit packages | | Departures where special payments have been made | Special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | Number | Cost £'000 | Number | Cost £'000 | Number | Cost £'000 | Number | Cost £s |
| **Less than £10,000** | - | - | 18 | 68 | **18** | **68** | 1 | 4 |
| **£10,001 - £25,000** | - | - | 5 | 68 | **5** | **68** | - | - |
| **£25,001 - 50,000** | - | - | 2 | 61 | **2** | **61** | - | - |
| **£50,001 - £100,000** | - | - | - | - | **-** | **-** | - | - |
| **£100,001 - £150,000** | - | - | - | - | **-** | **-** | - | - |
| **£150,001 - £200,000** | - | - | - | - | **-** | **-** | - | - |
| **Greater than £200,000** | - | - | - | - | **-** | **-** | - | - |
| **Total number of exit packages by type** | **-** | **-** | **25** | **197** | **25** | **197** | **1** | **4** |

Redundancy and other departure costs have been paid in accordance with the provisions of the national Agenda for Change scheme where payment has been made in lieu of notice, or the locally agreed MARS scheme which is based on national guidance. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages: other (non-compulsory) departure payments (audited information)

| | 2022/23 | | 2021/22 | |
|---|---|---|---|---|
| | Agreements Number | Total Value of Agreements £000 | Payments agreed Number | Total value of agreements £000 |
| Voluntary redundancies including early retirement contractual costs | 1 | 34 | - | - |
| Mutually agreed resignations (MARS) contractual costs | 1 | 27 | 18 | 719 |
| Early retirements in the efficiency of the service contractual costs | - | - | - | - |
| Contractual payments in lieu of notice * | 22 | 132 | 19 | 108 |
| Exit payments following Employment Tribunals or court orders | - | - | | - |
| Non-contractual payments requiring HMT approval ** | 1 | 4 | - | - |
| **Total** | **25** | **197** | **37** | **827** |

*any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice.

## Apprenticeships

Apprenticeships continue to be an ideal way for anyone to earn a wage while gaining a valuable qualification.

Hiring apprentices helps all businesses and organisations employ local talented people and supporting career aspirations, benefitting the organisation, the person and the local community. Apprentices provide organisations such as the NHS with a motivated, talented, skilled and qualified workforce.

Being an apprentice provides opportunities to gain a nationally recognised qualification, develop professional skills, while earning a salary.

we currently employ almost 300 apprentices in many clinical, allied healthcare and business roles. The number of apprentice employees increases annually.

Since 2017 we have supported over 500 apprentices through their apprenticeship and into successful working roles. Some of our apprentices go on to achieve a BSc degree in their chosen career. This includes nurses, occupational therapists, physiotherapists, radiographers, healthcare science practitioners in cardiology, Respiratory and engineering, managers and senior leaders etc.

All apprenticeship training programmes are paid for by the employer organisation, and enable those who may not be in a position to take on a student loan to achieve their career aspirations from a level 2 apprenticeship up to and beyond a BSc apprenticeship.

As the largest employer in the region, we truly value our people and use the resources available to us for the benefit of the employee and ensure that nobody is excluded, discriminated against, or left behind.

We are an inclusive organisation and we continue to support as many people as possible into our organisation. Apprenticeship opportunities provide another respected route into our organisation as well as supporting the career aspirations of those who currently work with us.

This concludes the Staff Report for 2022/2023.

Liz Davenport, Chief Executive 28 June 2023

## PART V – GOVERNANCE STATEMENTS

### Statement of the Chief Executive's responsibilities as the Accounting Officer of Torbay and South Devon NHS Foundation Trust:

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Torbay and South Devon NHS Foundation Trust NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Torbay and South Devon NHS Foundation Trust NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Liz Davenport, Chief Executive
28 June 2023

## Our Governance

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards. While doing this, the Board:

- monthly in order to discharge its duties effectively
- systems and processes are maintained to measure and monitor the organisations effectiveness, efficiency and economy as well as the quality, of its healthcare delivery
- reviews performance against regulatory and contractual obligations, approved plans and objectives. Metrics, measures and accountabilities have been developed to assess progress and delivery of performance
- all directors are encouraged to constructively challenge each other and the Executive, whilst maintaining and acknowledging their collective responsibility
- Non-Executive Directors scrutinise the performance of the Executive Directors in meeting agreed goals and objectives and monitor the reporting of performance. If a Board member disagrees with a course of action it is minuted accordingly. The Chairman would then hold a meeting with the Non- Executive Directors. If the concerns cannot be resolved this should be noted in the Board minutes
- Non-Executive Directors are appointed for a term of three years by the Council of Governors. The Council of Governors has the authority to appoint or remove the Chairman or the Non-Executive Directors at a general meeting. Removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors
- Non-Executive Directors are determined by the Board to be independent
- no voting Board or Council of Governor member holds a Director or Governor position within any other NHS Foundation Trust
- operates a code of conduct that builds on our organisational values to reflect high standards of probity and responsibility
- in discussion with the Council of Governors a Non-Executive Director covers the role of Senior Independent Director
- the Chairman ensures that the Board of Directors and the Council of Governors work together effectively and that directors and governors receive timely and clear information that is appropriate to carry out their duties
- the Chairman holds regular meetings with Non-Executive Directors without the Executive Directors present
- no independent external adviser has been a member of or had a vote on the Committees responsible for the appointments or remuneration of Executive or Non-Executive Directors
- the Committee responsible for setting levels of remuneration for Executive Directors has delegated authority from the Board to do so
- independent professional advice is accessible to the Non-Executive Directors and the Trust Secretary via the appointed independent external auditors and/or via external legal firms
- there is no full-time Executive Director that takes on more than one Non-executive Director role of another NHS Foundation Trust or another organisation of comparable size and complexity
- all Board meetings and Board Committee meetings receive sufficient resources and support to undertake their duties
- a going concern report is undertaken annually

- effective mechanisms are in place to ensure co-operation with relevant third-party bodies
- in accordance with the Code, our organisation is led by the Board of Directors who have joint and several responsibilities for the exercise of the powers of the Foundation Trust. Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted. The Board does not consider that its performance or balance was significantly impacted during any period of interim arrangements.

The Council of Governors:

- represents the interests of the organisation's members and partner organisations in the local health economy.
- has a code of conduct in place to ensure Governors adhere to our best interests and values
- holds the Board of Directors to account for our performance and receives appropriate information on a regular basis
- governors are consulted on the development of our forward plans and arrangements are in place for them to be consulted on any significant changes to the delivery of our business plan if so required
- the Council of Governors meet on a regular basis in order for them to discharge their duties
- the governors elect a lead governor. As lead governor, the main function is to act as a point of contact with NHSE, the directors and governors continually update their skills, knowledge and familiarity with our organisation and our obligations, to fulfil their role on various Boards and Committees
- our constitution is available on the website and outlines the clear policy and fair process for the removal from the Council of Governors of any governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties
- the performance review process of the Chairman and Non-Executive Directors involves the governors, is conducted by the Senior Independent Director and in accordance with NHSE guidance. Each Executive Director's performance is reviewed by the Chief Executive. The Chairman reviews the performance of the Chief Executive
- the Committee responsible for setting remuneration of Non-Executive Directors and the Chairman adhere to the NHSE guidance when reviewing levels of remuneration
- the Committee responsible for the appointment of Non-Executive Directors comprises a majority of governors
- the Chief Executive ensures that the Board of Directors and the Council of Governors act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman contemplates a course of action involving a transaction which the Chief Executive considers infringes these requirements, the procedures set by NHSE for advising the Board and Council for recording and submitting objections to decisions will be followed. During 2022/23 there have been no occasions on which it has been necessary to apply the NHSE procedure
- our staff are required to act in accordance with NHS standards and accepted standards of behaviour in public life (Nolan Principles).

- We ensure compliance with the Fit and Proper Person (FPP) requirement for the Board of Directors. All existing Directors completed a self- declaration. All new appointments are also required to complete the self- declaration and the full requirements of the FPP test have been integrated into the pre-employment checking process.

## Statement of compliance with the NHS Foundation Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance, as published and applicate for this financial year, on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, originally issued in 2012. It is noted that a new code of governance has been published for NHS providers for year ending 31 March 2024, this will be reflected in next years' accounts and adhered to within the year commencing 1 April 2023.

NHS Foundation Trusts are required to provide a specific set of disclosures in the annual report to meet the requirements of the Code of Governance.

Information relating to governance systems and processes is detailed in the Annual Report, and in particular the Annual Governance Statement. Details of the Constitution of the Board are given in the Accountability Report.

## Mandatory disclosures

| ***Relating to*** | ***Code provision*** | ***Summary of requirement*** | ***Location in Annual Report*** |
|---|---|---|---|
| Board and Council of Governors | A.1.1 | The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved.<br>The annual report should also include this schedule of matters or a summary statement of how the board of directors operate, including a summary of the types of decisions to be taken by the board and council which are delegated to the executive management of the board of directors. | Accountability Report Pages xxx<br><br>Governance Statements – Page xxx |
| Board, Audit Committee, Nominations and Remuneration Committee(s) | A.1.2 | The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees.<br>It should also set out the number of meetings of the board and those committees and individual attendance by directors. | Accountability Report Pages xxx |
| Council of Governors | A.5.3 | The annual report should identify the members of the council of governors, including the description of the constituency or organisation they represent whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the lead governor. | Accountability Report Pages xxx |
| Council of Governors | FT ARM* | The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors. | Accountability Report Page xxx |

| Board | B.1.1 | The board of directors should identify in the annual report each of the non- executive director it considers to be independent, with reasons where necessary. | Accountability Report Page xxx |
|---|---|---|---|
| Board | B.1.4 | The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Foundation Trust. | Accountability Report Page 46 and Appendix A - Pages xxx |
| Board | FT ARM* | The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated. | Remuneration Report Pages xxx |
| Nomination and Remuneration Committee(s) | B.2.10 | A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. | Accountability Report Page xx |
| Nomination and Remuneration Committee(s) | FT ARM* | The disclosure in the annual report on the work of the nomination committee(s) should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non- executive director. | Not applicable |
| | | A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report.Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. | No other significant commitments to report |
| Council of Governors | B.5.6 | Governors should canvass opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | Accountability Report Pages xxx |
| Council of Governors | FT ARM* | If during the financial year, the governors have exercised their power under paragraph 10C of Schedule 7 of the NHS Act 2006, to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties, then information on this must be included in the annual report. | Not applicable |
| Board | B.6.1 | The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. | Accountability report Page xx |
| Board | B.6.2 | Where there has been an external evaluation of the board and/or governance of the Foundation Trust, the external facilitator should be identified in the annual report and statement made as to whether they have any other connection to the Foundation Trust. | Not applicable for the reporting period |
| Board | C.1.1 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are | Accountability Report Page xx |

| | | | |
|---|---|---|---|
| | | fair, balanced and understandable and provide information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). | Annual Governance Statement page xx |
| Board | C.2.1 | The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. | Governance Statements Pages xx |
| Audit Committee/ control environment | C.2.2 | A Foundation Trust should disclose in the annual report:<br>if it has an internal audit function, how the function is structured and what role it performs; or<br>if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. | Accountability Report Pages xx |
| Audit Committee/ control environment | C.3.5 | If the council of governors does not accept the audit committee's recommendation on the appointment, re-appointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. | Not applicable |
| Audit Committee | C.3.9 | A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include:<br>the significant issues that the committee considered in relation to financial statements, operations and compliance, and how those issues were addressed;<br>an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length or tenure of the current audit firm and when a tender was last conducted; and<br>if the external auditor provided non- audit services, the value of the<br>non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. | Accountability Report Pages xxx |
| Board, Nomination and Remuneration Committee | D.1.3 | Where an NHS Foundation Trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. | Not applicable |
| Membership | E.1.4 | Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report. | Appendix B Pages xxx |
| Board | E.1.5 | The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at | Accountability Report Pages xx |

| | | | |
|---|---|---|---|
| | | meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. | |
| Board/ Membership | E.1.6 | The board of directors should monitor how representative the NHS Foundation Trust's membership is and how the level and effectiveness of member engagement and report this in the annual report. | Accountability Report Page xx |
| Membership | FT ARM* | The annual report should include:<br>a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;<br>information on the number of members and the number of members in each constituency; and<br>a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members. | Accountability Report Pages xxx |
| Board/Council of Governors | FT ARM* | The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. | Accountability Report Pages xxx |
| *FT ARM disclosures are required by the NHS Foundation Trust Annual Reporting Manual rather than the NHS Foundation Trust Code of Governance. | | | |

## Comply or explain disclosures

NHS Foundation Trusts are required to provide a specific set of disclosures in relation to the provisions within Schedule A of the NHS Code of Governance. We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis and has complied with the Code during 2022/23, except for the following:

| | |
|---|---|
| A3.1 | The Chairman has been reappointed for further one-year term of office, being his tenth year in post. This re-appointment was made in accordance with the direction of NHS England to ensure consistent strategic leadership due to the Devon systems status within SOF4. Due consideration was given to the perception of independence of the postholder when extending the term of office and the balance of risk. |
| B.1.2 | During the year there was a period where there was an equilibrium of Non-Executive Directors (NEDs) and Executive Directors (EDs), as opposed to a positive balance of NEDs. This arose due to an unexpected NED departure and was managed promptly through the recruitment and appointment of two new NEDs in August and September 2022. |

## Annual Governance Statement

### Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that our organisation is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

### The purpose of the system of internal control

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Torbay and South Devon NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

### Capacity to handle risk

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the organisation and these meet all statutory requirements and adhere to guidance issued by NHS England in respect of governance and risk management.

We have a risk management strategy, which is reviewed and endorsed by the Board of Directors. The strategy provides the framework for managing risks across the organisation which is consistent with best practice and Department of Health and Social Care guidance. The strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of sub-committees that scrutinise and review assurances on internal control. These include the Audit and Risk Committee, Quality Assurance Committee, People Committee and the Finance, Performance and Digital Committee. Underpinning these sub-committees are the Executive-led groups – including the quality improvement group, risk group and other groups managing the operational delivery of information management and technology, estates and people.

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality Assurance Committee. The Board of Directors receives a report from the Chair of each of the Board sub-committees. The Board of Directors also receives the Board assurance framework and corporate risk register at each meeting.

The risk group oversees all risk management activities across the organisation to ensure that the correct strategy is adopted for managing risk, controls are present and effective, action plans are robust for these risks that are being actively managed and that high risks are scored appropriately. The risk group is chaired by the Chief Finance Officer. Membership comprises all Executive and Associate Directors; other standing attendees include the Director of Health Informatics, Director of Corporate Governance, Corporate Governance Manager and the Risk Officer. In addition, the Executive Directors have in place a process whereby all significant risks to the achievement of service delivery unit and directorate objectives, NHS England governance and compliance requirements and Care Quality Commission regulations are kept under review.

Established governance arrangements maintain effective risk management arrangements across the Integrated Service Units (ISUs) maintain risk registers and report accordingly. The system directors for each of the ISUs are responsible and accountable to the Chief Operating Officer for the quality of the services they manage and to ensure that any identified risks are placed on the ISU risk register. All such risks are reviewed by the relevant ISU and any escalation as required is managed in accordance with the risk reporting process. It should be noted that the ISU structure will change in the year ended 31 March 2024 following a clinical governance review.

While the Chief Executive has overall responsibility for the management of risk, other members of the Executive team exercise lead responsibility for the specific types of risk as follows:

| | |
|---|---|
| Strategic risk | Chief Executive |
| Clinical and quality risks | Chief Nurse/Medical Director |
| Financial risks | Chief Finance Officer |
| Workforce risks | Chief People Officer |
| Clinical staffing risks | Chief Nurse/Medical Director |
| Operational risks | Chief Operating Officer |
| Information management and technology risks | Director of Transformation and Partnerships |

All Board level directors are responsible for ensuring there are appropriate arrangements and systems in place to identify and assess risks and hazards, comply with internal policies and procedures, and statutory and external requirements and integrate functional risk management systems and develop the assurance framework. These responsibilities are supported operationally by service unit managers.

All members of staff have responsibility for participation in the risk/patient safety management system, through:

- awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments
- compliance with all legislation relevant to their role, including information governance requirements set locally by the organisation
- following all our policies and procedures
- reporting all adverse incidents and near misses via our incident reporting system
- attending regular training as required ensuring safe working practices
- awareness of our patient safety and risk management strategy
- knowing their limitations and seeking advice and assistance in a timely manner when relevant.

We recognise the importance of supporting staff. ISU and directorate risk management activities are supported by a risk management training programme, principally delivered by the risk officer,. Executive Directors and Non-Executive Directors are provided with risk management development on an individual basis or collectively at Board seminars.

We continue to maximise our opportunities to learn from other Foundation Trusts (particularly those who achieve outstanding CQC ratings), internal/external audit and continuous feedback is sought internally to ensure the systems and processes in place are fit for purpose. The findings are taken to the relevant Executive lead and/or Committee to ensure that any learning points are implemented. A wider distribution of learning points for staff is disseminated via staff briefings and bulletins.

In addition to the organisation reviewing all internally driven reports, we adopt an open approach to the learning derived from third party investigations and audits, and/or external reports. We have also adopted a pro-active approach to seeking independent reviews should concerns be raised of a significant magnitude.

I have ensured that all risks of which I have become aware are reported to the Board of Directors. All new significant risks are escalated to the Executive Lead and reviewed and validated by the risk group. There is a regular review of risks on the Board assurance framework by the Board of Directors as a collective Board and at Board Committee; the purpose of which is to scan the horizon for emergent threats and opportunities, and consider the nature and timing of the response required to ensure the risk is kept under control. Risk and assurance is also discussed annually at Board development days.

## The risk and control framework

Risk is managed at all levels of the organisation and is co-ordinated through an integrated governance framework consisting of a number of key groups that report on a regular basis to either the Quality Assurance Committee, People Committee, Finance, Performance and Digital Committee, Building a Better Future Committee or Audit and Risk Committee.

The key groups are: safeguarding / inclusion group, quality improvement group, serious adverse events group, people and education governance group, estate performance and compliance group, transformation and cost improvement programme group, finance delivery group, capital infrastructure and delivery group, information management and IT group, risk group, building a brighter future programme group and integrated governance group.

Our risk management strategy has defined our approach to risk throughout the year and provides an integrated framework for the identification and management of risks of all kinds, whether clinical, non-clinical, corporate, or financial and whether the impact is internal or external. This is supported by a Board assurance framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management. At each Board of Directors meeting, papers are provided with a report summary sheet through which directors identify links to one or more corporate objectives and one or more overarching corporate level risks / themes.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the risk management policy. Across a range of domains, the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. Our risk tolerance is defined as: ‘the amount of risk the Foundation Trust is prepared to accept, tolerate or be exposed to at any point in time’.

In setting a tolerance, it has been determined that any risks to the delivery of the organisation’s objectives with a current risk score of 15 or above will be brought through the exception reporting process via the Risk Group and Board Sub-Committees to the Board of Directors if deemed to be a corporate level risk. Actions and timescale for resolution are agreed and monitored. Such risks are deemed to be acceptable by the Executive Team only when there are adequate control mechanisms in place and a decision has been made that the risk has been managed as far as is reasonably practicable. Risks scored below this level are managed by the relevant lead director, service unit or directorate.

The Risk Group receives reports on any risks which could impact on our strategic objectives, particularly those risks deemed to be ‘major’ or ‘catastrophic’ or which could escalate to these levels if action is not taken. The Risk Group also oversees the development of our long-term strategy and implementation of the risk management and assurance framework. A deep dive schedule was established during the year which ensures that significant risks (current risk score of 15) receive detailed scrutiny at the Risk Group, Audit and Risk Committee, Quality Assurance Committee, People Committee, Building a Better Future Committee or Finance, Performance, and Digital Committee meetings. Further information can be found within our risk management policy.

Significant risks (any with a current risk score of 15 or more in accordance with the risk scoring matrix) will be reported to and considered by the Risk Group. If it is deemed that a risk is a ‘corporate level’ risk, it will be added to the corporate risk register as described in our risk management policy or linked to an existing Corporate Level Risk with a shared theme.

The Risk Group reviews the corporate risk register to ensure that:

- the risk has been appropriately assessed and recorded
- actions plans/points are in place and leads identified and timescales for delivery
- the risk and action points/plans are monitored to completion.

Risks posing a threat to our strategic objectives are escalated to the Board assurance framework.

The Executive Team is responsible for:

- ensuring that programme and operational risks are actively managed within their areas of the business
- being owner and action owner of individual risks (including those delegated by the Chief Executive)
- devising short, medium, and long-term strategies to tackle identified risk, including the production of any mitigating action plans.

The Audit and Risk Committee has responsibility for the review of governance, risk management and internal control covering both clinical and non-clinical areas. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management (including regular review of the Board assurance framework and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives. The Audit and Risk Committee will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Audit and Risk Committee may review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation and make recommendation to the Board of Directors where appropriate. Where the Audit Committee feels that there is evidence of ultra-vires transactions, evidence of improper acts or if there are other important matters that the Committee wishes to escalate, the Chair of the Audit and Risk Committee will raise these at a full meeting of the Board of Directors and, if appropriate, exceptionally to NHSE. After each meeting, the Chair of each Committee is required to provide a summary report to the Board of Directors addressing ‘key issues’ and any ‘key decisions/recommendations.

The Board of Directors evaluates the Board assurance framework at each meeting with any exceptions being reported at other times of the year. Corporate level risks / themes are included on all Board papers in relation to the action being taken to manage these risks.

An example of where risk management is incorporated into our core business is in relation to the integrated finance, performance, quality and people Board report. The monthly report to the Board of Directors provides commentary on performance and on key variances and improvements. The report is created by the outcomes and actions from various meetings, for example, the integrated governance group

meetings and Executive team weekly meetings. Each of the Board Sub-Committees also reviews the section appropriate to scope of their work at each of their meetings, for example the People Committee receive the people section of the integrated Board report.

We ensure that public stakeholders are involved in managing risks which impact on them. The Council of Governors, having responsibility for representing our members and the public, receive briefings from the Chief Executive and Chair and have regular dialogue with the Chair, Executive Directors and Non-Executive Directors.

Matters pertaining to our performance, both quality, financial and people-related, and any changes to our services are reported.

Discussions have also been ongoing throughout the year with commissioner colleagues to ensure all key access targets are being managed from within available resource. There have been regular contract management meetings with our lead commissioners and councils.

### Principal risks

Our risk management processes have identified a number of risks for 2022/23. These system-wide risks relating to unprecedented challenges as a consequence of the COVID-19 pandemic as well as achieving financial sustainability and controlling costs, while having sufficient monies to maintain the digital and estate infrastructure to ensure continued patient safety, quality and productivity have been considered and reflected in the Board assurance framework. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

The risks to the achievement of our strategic objectives are described in the Board assurance framework for 2022/23 as:

### Board Assurance Framework (BAF)

*BAF Reference 1: quality and patient experience*
*Objective: to deliver high quality health and care services, achieving excellence in health and wellbeing for patients and local community*

- risk of not meeting pace and scale of change required to minimise harm and poor patient experience and meet System Oversight Framework 4 exit criteria
- risk of clinical leadership capacity inability to lead change
- risk of gaps in leadership capacity and capability across new care group structure
- risk of gaps in expertise and capacity within the quality and patient safety functions
- risk of capacity and capability inability to monitor /interrogate business/clinical Intelligence data
- risk of quality /governance systems across organisation and within the newly emerging care group structure not being able to mature quickly enough

*BAF Reference 2: people*
*Objective: to build a culture where our people feel safe, healthy and supported*

- risk in relation to turnover of leaders/managers against measures of vacancy controls
- risk of inadequate workforce capacity and resilience, burnout/fatigue arising from ongoing significant operational pressures

- risk of lack of talent pipeline and supply, recruitment and retention of staff across specific specialties/professional groups, due to no strategic business or workforce planning
- risk of failure to fully implement our people promise – specifically leadership framework, management training and just and learning culture
- risk of unaffordable workforce costs due to increased use of bank and agency staff
- risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
- risk of inability to build a culture where people feel safe, healthy and supported due to rising number of EDI related grievances and a reported decline in workplace experience by those with disabilities or from a BAME background.

*BAF Reference 3: financial sustainability*
*Objective: to achieve financial sustainability and deliver the ICS three-year financial recovery plan, enabling appropriate investment in the delivery of outstanding care*

- inflation outstrips funding available resulting in a deterioration in financial performance
- digital and physical environments are not fit for purpose
- recruitment and retention are difficult for highly skilled clinical staff
- failure to comply with best practice guidance such as GIRFT and model hospital
- material differences between income and costs for specific services most notably adult social care
- capacity and capability of senior budget holders is variable
- gaps within the CIP programme
- ongoing challenges with data quality and information availability, driven by limited capability of digital systems and significant capacity issues in data warehousing
- GIRFT response, has been inconsistent, missing an opportunity to implement best practice
- impact of operational pressures on ability to deliver financial plans.
- reintroduction of activity-based payments on the horizon with limited in-house capacity to support
- productivity has not recovered to pre-Covid levels and recovery funding is often non-recurrent in nature

*BAF Reference 4: estates*
*Objective: to provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times*

- the estate is heavily dilapidated with £60m of backlog reported to NHSEI through the Estates Return Information Collection (ERIC) in 2022 (half is high and significant risk)
- insufficient engineering infrastructure capacity, capability and resilience to maintain activity and safe environments
- inability to improve and reconfigure the estate due to significantly aged infrastructure and insufficient funding impacting the delivery of clinical activity (e.g. lack of suitable clinical rooms to meet demand, insufficient office-accommodation to meet needs of all clinical and non-clinical teams)
- aging premises, requiring additional servicing and repair

- premises infrastructure and layout not efficient for modern healthcare needs.

*BAF Reference 5: operations and performance standards*
*Objective: 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*

- imbalance between time of emergency admissions and discharges
- insufficient capacity in care home and domiciliary care market
- continued infection outbreaks resulting in reduced bed capacity and ability to move patients to the right bed
- insufficient internal and externally sourced capacity to manage elective demand
- inadequate information and data analysis to respond to emerging threats
- low skill level of staff in managing non-elective and elective demand.

*BAF Reference 6: digital and cyber resilience*
*Objective: to provide clinical and administrative IT systems, and supporting digital infrastructure, that efficiently and cost-effectively meet our clinical models of care and key business needs, and support the confidentiality, integrity and availability requirements of a modern health and care provider delivering 24/7/365 services.*

- potential for increase of licensing costs above inflation
- shift to annual maintenance fees for licenses impacting on revenue
- systems unavailable due to ransomware attacks
- inability to refresh IT hardware before it ceases to perform or becomes unsupported
- poor data centre/data network storage environment resulting in outages
- requirement to update software with patches can result in system failure
- inability to reprocure/re-provide end of life systems affecting business continuity.

*BAF Reference 7: Building a Brighter Future (BBF)*
*Objective: 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*

- uncertainty in the national funding availability within the New Hospital Programme
- significant increase in inflationary pressures impact overall affordability of the preferred option within the strategic outline case.

*BAF Reference 8: transformation and partnerships*
*Objective: to implement our plans to transform services, using digital as an enabler, to meet the needs of our local population*

- significant challenges in quality, safety, performance and financial improvement will require a large-scale change programme to be mobilised at pace
- ability to recruit the required level of expertise into the improvement and innovation team
- further requirement of improvement expertise within the ICS to deliver system-wide improvement programmes
- no standardised or co-ordinated approach to leading improvement programmes across the ICS
- basic IT and estate infrastructure is poor and does not enable significant levels of transformation at pace.

*BAF Reference 9: Integrated Care System*
*Objective: to create the conditions for collaborative working and delivery of shared goals in partnership with the ICS*

- our partnerships across the ICS are critical in securing improvements in the delivery of services for local people.
- the sustainability of clinical services requires networking across the ICS and the capacity to deliver change at pace
- there is an urgent need to standardise back-office processes and functions to deliver the appropriate transformation.

*BAF Reference 10: green plan/environmental, social and governance*
*Objective: to deliver on our plans and commitments to environmental sustainability*

- infrastructure across the estate is aged and not environmentally efficient
- the existing infrastructure is aged to a point where assets cannot be easily added or replaced with environmentally efficient ones (due to the condition of the infrastructure on to which they would be attached)
- sufficient focus and priority is not given to the implementation of our green plan as resource availability is limited and focussed on operational delivery and recovery.

### Financial, performance, people and quality risks

As we go into 2023/24, we have developed a series of improvement plans which will support our progress against the NOF 4 exit requirements as agreed with the ICS and NHS England Regional team. Outcomes will be measured by a monthly review of financial, quality, performance and people information by the Board, in addition to scrutiny of the impact of efficiency savings on patient safety and quality of service.

The People Committee provides assurance on activity to deliver and measure the impact of our people promise.

A Board Sub-Committee focusing on finance and performance is in place to provide additional scrutiny of productivity and the delivery of recovery plans for planned and cancer care, urgent care and diagnostics. There is a regular programme of specialty reviews which review progress against operational efficiency opportunities as demonstrated by the Getting it Right First Time programme. Our plans, which reconcile local strategic priorities with the ICS Devon forward plan have been developed to ensure recovery of operational performance and make progress towards a three-year financial recovery programme for Devon.

We have implemented a senior management-led governance groups (including the Recovery Group) as part of our oversight of operational and financial delivery and progress against NOF 4 requirements.  This has been the vehicle through which efficiency programmes are planned, managed as well as supported by external partners. Cost improvement programme delivery does however remain a significant challenge as we move in to 2023/24, with changes to the NHS financial regime, ongoing high levels of inflation, and a difficult industrial relations climate.

### Capital funding risks

We reported a deficit in 2022/23 and have seen reduced levels of underlying EBITDA associated over a number of years. This has significantly restricted the level of cash available for capital expenditure. As a result, we are reliant on external funding through public dividend capital to fund a significant proportion of its capital programme, such as essential repairs and replacements across all areas of expenditure, estates, information management and technology and medical equipment. The ability to invest in developmental capital necessary to further develop our care model has similarly been curtailed.

Nevertheless, we have access to significant amounts of national funding which has mitigated to a large extent the shortfall in internally generated cash. We are further developing further sources of finance through ongoing negotiation with NHSEI that will enable this risk to be addressed, including: a strategic estates partnership, lease options, bidding, largely through ICS processes for public dividend capital and, where appropriate and subject to the necessary approvals, debt financing (loans).

### System cost pressures

The pressure in the 2022/23 cost base reflects increased pressure on health services in general, and the significant focus on elective, diagnostic and cancer recovery. We have also continued its targeted investment programme in safer staffing and has relied heavily on in-sourcing and out-sourcing of elective and diagnostic services to recover performance against national targets. We continue to depend on agency medical and nursing staff in a number of shortage areas. Uniquely, and most significantly in our organisation, are pressures building in continuing health care and adult social care. This is largely the result of a number of providers withdrawing from the market or experiencing financial difficulties driven by inflation and staffing pressures. As we look forward to 2023/24, sustained inflation will be a significant risk to market sustainability in the residential and nursing care sector.

The NHS Devon system-wide plans for 2023/24 have been developed in conjunction with our partners and through the Board. These have been subject to significant external support through a panel of professional advisors and scrutinised by the regulator. The Board has acknowledged that we must continue to develop our planning and delivery models, and to this end we are implementing a revised operational structure. An enhanced accountability framework and programme management office supports this model.

The financial outlook is challenging and there is significant risk to achieving the necessary level of financial improvement within our organisation and across the ICS for Devon. Our cost saving and efficiency programme in 2023/24 amounts to £46.1m, a quantum never previously achieved, which will demand significant service redesign at pace.

## Urgent and emergency care

We will continue our improvement towards achieving the National UEC standards in 2023-24 specifically the 4 Hour Access Standard and 15 min Ambulance Handover Standard. The Trust will be working closely with the Emergency Care Improvement Support Team (ECIST) and the Regional Team to ensure plans are in place to support these measures. Internally an Urgent and Emergency Care Board has been established to further focus the impact on improvement.

As an integrated Care Organisation there will be a continued focus on patients with "No Criteria to Reside" (NCTR). The Trust has performed well against this metric in 2022-23. Moving into 2023-24 the opening of the Jack Sears Units provides the opportunity to go further on this standard and supports the plan of achieving 5% NCTR. This would be regarded as best practice in the region and builds on the positive reputation the Trust has developed in relation to pathway management for these patients.

## Elective Waiting time for routine care

During 2023-24 the Trust will continue to pursue improvements in our waiting times in line with National priorities, as noted in our Performance Analysis, pages xx. The target is to have all patients who are waiting longer than 65 weeks treated by 31st March 2024. The Trust has worked very closely with NHS England to develop robust plans to support these activities, currently we expect to have cleared all patients waiting longer than 78 weeks and to reduce our 65 week waits to <1,100. Two new modular theatres will be constructed and become operational in January 2024, increasing our day surgery capacity by 50%. National recommendations on the delivery of outpatient activities will be implemented and embedded, pathways will be streamlined and technical developments will enable patients to take more control of their clinical journey.

## Elective Waiting time for Cancer care

As explored within the Performance Analysis, above, the considerable improvements in our Cancer performance achieved in 2022-23 will be embedded and continued. Diagnosis of suspected Cancers and the treatment of our patients within 62 days will continue to be our main focus in the coming year. A 4th Endoscopy room will become operational in November and provide the capacity to maintain rapid diagnosis for suspected Gastro-intestinal Cancer for the longer term. The Trust is also fully engaged with Devon System plans to develop Community Diagnostic Centre's where capacity will be created in other critical diagnostic modalities.

The significant program of change in our Elective Care services described above will enable us to build upon our nationally recognised reputation for innovation in Day Surgery and Endoscopic diagnosis. Critical to this will be our ability to attract and recruit the very best people available. We know this will be a challenge and we will be inventive in our approach to ensure that our new facilities can deliver the highest standards of care for our patients.

## Compliance

### Care Quality Commission (CQC)

The Chief Nurse is responsible for ensuring compliance with our registration with the CQC. This is achieved by:

- reporting and keeping under review matters highlighted within inspections
- liaising with the CQC inspectors and senior clinicians and managers in response to any specific concerns raised by the CQC or by patients and members of the public
- engaging with the CQC inspectors in the inspection process and coordinating our response to inspections and any recommendations or actions that arise thereafter
- analysing trends from incident reporting, complaints and patient and staff surveys and sharing the learning from these across our services
- reviewing assurances on the effective operation of controls
- receiving assurances provides by internal audit and any clinical audit conclusions, which provide only limited assurance.
- engaging with the CQC at the standard Quarterly Engagement meetings and Monthly relationship meetings
- a yearly report on the trust's registration to Board

During 2022/23 we had no formal CQC inspection activity but continued our audit and assurance work on ensuring risk assessments were completed fully for each person, within 24 hours of admission to hospital, in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an ISU level, as well as at the Nutritional Steering Group and by exception to the Quality Improvement Group

### Care Quality Commission compliance declaration

At 31 March 2023, we remain fully cognisant of and maintain compliance with our registration requirements with the CQC. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

### Compliance with NHS Foundation Trust condition 4(8)(b)

The assurance process described in this statement allow the Board to issue an accurate Corporate Governance Statement, required under NHS Foundation Trust condition 4(8)(b) of NHS England's provider licence, as applicable during the financial year ended 31 March 2023. It is noted that a new provider licence was issued in the year, applicable 01 April 2023; the requisite reporting for which will be reflected in the annual report and accounts for year ended 31 March 2024.

### Communication with stakeholders

Our communications and engagement team works in partnership with the feedback and engagement team and the membership office to ensure that there are sufficient and robust mechanisms in place to inform the public about, and involve them in, our work.

Together we are committed to ensuring that patients, carers, staff and the public are listened to and have the opportunity to feedback on their experiences while also raising concerns and asking questions about any of our current and future activities. We work closely with our partners in the Integrated Care System for Devon (ICSD) and any formal consultation is led by the ICSD with our support and involvement as appropriate.

Our engagement and communications strategy aims to support meaningful conversations with our people and communities while our patient and service user experience of healthcare strategy helps us to hear and learn better from patient and carer experience.

This year we have undertaken public engagement with people who use our Emergency Department with the support of Healthwatch as well as focused engagement around men's health (again supported by Healthwatch).

A number of forums exist that allow the Board of Directors, Executive Directors and staff at all level to communicate with key stakeholders, including formal Board to Board and Executive to Executive meetings with local commissioners, local health and care providers, Health and Wellbeing Boards, Health Overview and Scrutiny Committees with our local authorities and regular meetings with local MPs and Healthwatch. We also have a growing number of patient and public engagement groups across our services which support us to listen to and learn from our people and communities.

These forums, supported by our other communications, engagement and feedback channels, provide a mechanism for any risks identified by stakeholders that affect us to be discussed for any action plans to be developed.

### Compliance with people strategies and 'developing workforce safeguards

Our people promise and plan was approved by our Board of Directors in 2021. In line with our people promise, we have processes to ensure that short, medium and long-term people plans and people systems to ensure services are safe, sustainable and effective. Further, as part of the safe staffing review, the Chief Nurse and Medical Director confirm that staffing is safe, effective and sustainable and meet the requirements of the National Quality Board and the Workforce Safeguards Guidance (NHSI 2018).

The Board continually reviews the effectiveness of its systems of internal control. The embedding of the strengthened governance framework supports the

provision of evidenced based assurance from ward to Board. The Board reviews the organisation's performance in the key areas of finance, activity, national targets, patient safety and quality and people in the form of an integrated quality dashboard. This includes the regular presentation of performance information against key quality, people and financial metrics to the Board and its Committees. The people section contains information on monthly staff sickness as well as rolling 12-month sickness absence, staff turnover and use of temporary staffing, as well as performance against the annual staff survey. These are high level organisational metrics and data that we will continue to collate, review and analyse each month. These people metrics, together with quality and outcomes indicators and productivity measures form part of the Integrated Performance Report. A more detailed version of the Workforce metrics are reviewed by the People Committee, within the context of delivery of our people promise.

The aim of our people promise is to build a healthy culture at work where our people feel safe, healthy and supported.

Key priorities were developed based on local evidence:

1. define and deliver a consistent, compassionate and Inclusive Leadership & Management approach that is motivating, empowering and encourages accountability
2. making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities.

To deliver on these two priorities, and continually improve the experience of our staff in order to deliver the best possible care, we have identified six deliverables. Under each deliverable are detailed project plans that are reported into our People Promise Programme Board and People Committee:

- Co-Create leadership framework & descriptors
- Leadership recruitment and development is based on this framework
- Equipping managers with the essential skills and confidence
- Support organisational reshape using span of control and engagement outcomes
- Workforce transformation programme to deliver clear enabling data and people process
- Development of robust strategic workforce plans and process, driving career pathways, learning/development

In terms of the wider context, we remain fully engaged with the Devon system workforce strategy, of which the main focus is centered on developing a culture and structure that facilitates trust, involvement and innovation and local empowered decision making. There is also work underway to develop a Devon-wide workforce plan in line with the Devon long term strategy. Within Torbay and South Devon we have recruited a strategic workforce planning lead, to ensure alignment to the ICS and development of both short and long term workforce planning in line with our Building a Brighter Future submission requirements.

### Compliance with 'Managing Conflicts of Interest in the NHS' guidance

We have published on our website, an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by us with reference to the guidance) within the past 12 months as required by the '*Managing Conflicts of Interest in the NHS*' guidance published by NHS England.

### Compliance with NHS pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

### Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisations' obligations under equality, diversity and human rights legislation are complied with.

We are committed to providing an inclusive and welcoming environment for all our staff, patients, clients, service users, carers and families. We are striving to create a culture of inclusion for all.

A range of control measures are in place to ensure the organisation complies with its obligations under equality, diversity and human rights legislation. Performance is monitored through the collection of statutory data and action plan which report through the People Committee.

The Board of Directors receives reports on diversity and inclusion issues from the Chief Nurse (patient and service user updates) and the Chief People Officer (people updates). These include any updates or changes in national mandates together with any risks or challenges.

### Compliance with Climate Change Act and the adaptation reporting requirements

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and the adaptation reporting requirements are complied with and in line with NHS net zero targets.

### Review of economy, efficiency, effectiveness, and use of resources

Directors are responsible for putting in place proper arrangements to secure economy, efficiency, and effectiveness in our use of resources. We have established several processes to ensure the achievement of this. These include:

- clear processes for setting, agreeing, and implementing strategic objectives based on the needs of the local population, reflecting the priorities of key partners and the Department of Health and Social Care. This includes a clear strategy for patient, client, service users, carers, and public involvement as well as our governors and public members, providing a key focus for our engagement work within Torbay and South Devon. Established objectives are supported by quantifiable and measurable outcomes
- clear and effective arrangements for monitoring and reviewing performance which include a comprehensive and integrated performance dashboard used monthly in the performance management of health and social care services and reported to the Board of Directors. The integrated finance, performance, quality and people report details any variances in planned performance and key actions to resolve them
- there is also a performance management regime embedded throughout the organisation including weekly capacity review meetings, financial recovery planning meetings, executive reviews of services, budget reviews (undertaken monthly) and regular work to ensure data quality
- Committees consider reports of external regulators and bodies, with improvement action plans developed and their implementation monitored where and as necessary
- through the Finance, Performance and Digital Committee, we have arrangements for planning and managing financial and other resources in place. These are encompassed in the Scheme of Delegation and the Standing Financial Instructions

- we use other benchmarking tools such as the Model Hospital productivity metrics to demonstrate the delivery of value for money and identify opportunities for improvement. We continue to develop our reference cost reporting data to ensure services are being provided as efficiently as possible. For procurement of non-pay related items, we have a clear procurement strategy and collaborate with other NHS bodies to maximise value through the NHS south west peninsula procurement alliance.

### Compliance with information governance requirements

Continuous improvement and maintenance of good information governance standards is a key priority for the Trust. This is reflected in the Trusts commitment to the national standards set out in the Data Security and Protection Toolkit (DSPT), completed annually.

Completion of DSPT demonstrates that we are compliant with the following:

- General Data Protection Regulation (GDPR)
- compliance with the expected data security standards for health and social care for holding, processing or sharing personal data
- readiness to access secure health and care digital methods of information sharing, such as NHS mail and Summary Care Records
- good data security to the CQC as part of the Key lines of Enquiry (KLOEs).

We have appointed key roles to support our commitment to data protection by design and default. These roles are the champions of appropriate data capture, processing, security and sharing by the organisation:

- Senior Information Risk Owner (SIRO), held by Executive Director of Transformation and Partnerships is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level
- Caldicott Guardian, held by Consultant for pain management and Anaesthesia is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
- Data Protection Officer (DPO), held by Head of Records, IG, DP and FOI is the expert in data protection and reports to the most senior levels within the organisation on risks to the privacy of individuals, and threats to the organisation

The recent Information Commissioner's Audit assessment confirmed a high level of assurance for governance and accountability, with a reasonable level of assurance for data sharing. During 2023 the areas identified for improvement have been actioned, with ongoing work to improve the procurement process, including ongoing assessment of existing contracts.

The Data Security and Protection Toolkit is supplied by NHS Digital to support the performance monitoring of Information Governance. We submitted 'standards met' for 2022/23, and expect to meet the same for 2023/24.

Information Governance incidents and risks are recorded on our risk management system. These are monitored by the Head of Information Governance for guidance and support in resolution. Summary reports and highlighted risks are discussed at information governance steering group (IGSG) chaired by the SIRO.

Incidents that score in line with regulated reporting are reported to the ICO – see summary below:

| Description of incident: | Action taken (Investigation) | Lessons learned | ICO Feedback |
|---|---|---|---|
| A major supplier to the healthcare sector (Advanced Computer Software Group Ltd) suffered a cyber-attack that caused significant disruption across the UK. The incident resulted in several IT systems being taken offline. The relevance to our Trust is the Carenotes system which is used for electronic patient record software for children, young people and families | Continuous specialist meetings to recover services, and recover data. | application of multi system providers across the Devon system supported a swift recovery of daily operations. Learning to be included to IT tenders | National impact – reporting aided central assessment of scale of impact for the ICO. No specific response to the Trust |
| Phone call from service user to health visitor. Service user upset because 'patient held record' was not given back to service user when they left the hospital, the hospital had sent record to an unknown person. This person used social media to contact service user to say they had the record. sensitive personal information potentially disclosed. | Under investigation | | |

| Complaints received from the ICO | Outcome |
|---|---|
| Subject Access Request – part refusal of disclosure. The disclosure time frame was delayed, beyond statutory timescales. | Upheld – The ICO approved disclosure redaction but upheld based on timescale breach. |
| Subject Access Request - part refusal of disclosure. The disclosure was delayed beyond statutory timescales. | Upheld – Statutory timescale breached. |
| Query over legal basis for processing of service user data. | Not Upheld - ICO requested the Trust communicate the Privacy Notice and an explanation to the complainant, which was duly done. Bespoke training was delivered, and learning taken to be implemented in future training. |

The Trust is committed to a culture of openness and transparency as evidenced in the wide reporting of incidents. Incidents involving a breach of confidentiality, security, and records management are recorded on our incident reporting system, are assessed by the information governance team, with summary reports presented to the IGSG as a sub group of the Information Management and Technology Group (IM&T).

## Data quality and governance

Performance dashboards are used across the organisational governance structures to give monthly oversight of key metrics covering quality, workforce, performance and finance. Each of the specialist areas has its own processes for assurance on data quality and reporting accuracy. Fortnightly, performance, risk and assurance meetings are held by service leads with oversight from the Chief Operating Officer. Performance benchmarking including model hospital and third-party benchmarking including Dr Foster, 'Gooroo' Planner (referral to treatment data ('RTT') and NHSEI

performance benchmarking is used to triangulate data and support assurance of data quality and reporting accuracy.

Clinical coding is a key source of intelligence for us, creating an asset that is used as a key intelligence resource, and carries financial implications. During COVID the coding team switched to a home working model which saw a decrease in quality due to staff not having access to paper records. Incident data and medical record audit data can be used to assess the quality of paper medical records. There are recordings of records found to hold documents relating to different patients, incorrectly filed and potentially acted upon, causing a clinical risk. These long-standing issues are recognised across the NHS and are a factor in the electronic patient record (EPR) investment we are making. Training is in place to promote paper-based record keeping standards.

The Information Assurance Group, run by the Head of the Data Warehouse assesses data quality in the Trust Information Assets and provides assessment and assurance to the IM&T group, as a route to the Board. A primary focus across the Health Informatics Service (HIS) has been initial consideration in readying the organisation for an EPR development; one area identified for improvement is the data held in the Electronic Staff Record (ESR).

We have previously implemented recommendations from the commissioned PWC review of data quality which was part of the annual plan assurance process. In 22/23, an example of quality assurance work was the commissioning of a third party organisation to assess data quality in waiting lists, this process followed a full governance assessment process including DTAC; outcomes from this work will be delivered in 23/24. Our Data Warehouse team has worked nationally to ensure that the script, pull and disclosure of information is accurate, following the local identification of a national glitch in request and assessment.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, corporate and clinical audits as well as operational and governance reporting mechanisms, supported by the knowledge, capability and accountability of the executive managers and clinical leads, each of whom have responsibility for the development and maintenance of the internal control framework in their respective areas. I have also drawn on performance information available to me, as well as comments made by the external auditors in their management letter and other reports.

I have been advised on effectiveness of the system of internal control during the year by the Board, and its sub-committees: including the Audit and Risk Committee; Quality Assurance Committee; Finance, Performance, and Digital Committee; Building a Brighter Future Committee and People Committee, and in addition the Executive Group and risk group. Where identified, weaknesses are addressed or a plan is put into place to mitigate them, so as to ensure continuous improvement of the system is in place.

Core documentation underpinning our system of internal control (including accountabilities and delegations) include but is not limited to: the Trust Licence and Constitution, Committee Terms of Reference, Matters Reserved to the Board, standing orders, scheme of delegation and standing financial instructions as well as both corporate and operational policy, procedure guidelines and standard operational procedures.

The Board assurance framework, as a mechanism for monitoring strategic delivery in a risk-based way, provides me with evidence of the effectiveness of controls and that any gaps are being addressed with appropriate action. My review has also been informed by the major sources of assurance on which reliance has been placed during the year.

These sources include reviews carried out by our external auditor Grant Thornton LLP, Deloitte LLP, Care Quality Commission, Internal Audit, Good Governance Institute and the Health and Safety Executive.

The following Committees and groups are involved in maintaining and reviewing the effectiveness of the system of internal control:

- the Board of Directors has overall accountability for the governance arrangements, including the committee structure, and ensuring we adhere to our constitution and apply our standing orders, scheme of delegation and standing financial instructions correctly. The Chairs of each of the Board sub-committees present a report to the next available Board meeting for the purpose of providing assurance on matters within its terms of reference. Urgent matters if requiring escalation to the Board are reported by the Committee Chair in the intervening period. The Board has agreed, in conjunction with the Council of Governors, the strategic objectives for the organisation. The Executive Directors have assessed
- the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in our Board assurance framework document reviewed regularly by the Board of Directors;
- the Audit and Risk Committee is responsible for establishing an effective system of internal control and risk management and provides an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity by reviewing the statement on internal effectiveness and Annual Governance Statement. Reports from the internal auditors and external auditor also provide assurance. The Committee also reviews on a regular basis, the risks that are described in the Board assurance framework. The Committee has oversight of and relies on the work of the risk group to monitor the risk management process and risk registers. The Committee has oversight of expressions of concerns and whistleblowing arrangements. The Audit and Risk Committee is chaired by a suitably qualified Non-Executive and membership comprises the Chairs of each of the Board Sub-Committees;
- the Quality Assurance Committee provides the Board of Directors with assurances of clinical effectiveness through scrutiny of patient quality and safety, patient experience, medicines management and staffing. It monitors selected quality metrics and ensures the organisation has robust systems in place to learn from experience. It receives reports from specialist governance groups and Boards e.g. statutory safeguarding partnership boards; patient safety; and serious incidents and undertakes a deep-dive review into a service or specialty at

each meeting. The Quality Assurance Committee is chaired by a Non-Executive Director and reports to the Board of Directors;

- the Finance, Performance and Digital Committee oversees, co-ordinates, reviews and assesses our 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. The Committee provides the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on our financial viability and sustainability. It provides detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board of Directors. It also assesses and identifies risks within the finance, performance and digital portfolio and escalates as appropriate. The Finance, Performance and Digital Committee is chaired by a Non-Executive Director and reports to the Board of Directors;
- the Building a Brighter Future Committee was established in 2020 for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme and to support the successful achievement of the programmes investment objectives and realisation of the stated benefits. It also aims to assure the Board of the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable;
- the risk group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the risk management strategy. It promotes effective risk management and compliance and supports maintaining a dynamic Board assurance framework and risk management database where risks are registered. It also ensures locallevel responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of our activity where robust controls are not evident in order to raise standards and ensure continuous improvement. The risk group is chaired by the Chief Finance Officer.

My review is also informed by the Head of Internal Audit Opinion which states that satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and controls are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives.

During 2022/23, internal audit undertook 16 substantive reviews and a high-level assessment of our governance arrangements, all of which informed the Head of Internal Audit Opinion for 2022/23. Internal audit reports are received by the Risk Group for review and action and are presented to the Audit and Risk Committee for assurance. Action plans and progress are reported in detail to each subsequent Audit and Risk Committee meeting as part of internal audit's follow-up process. This process includes a programme of review of improvements in practice in response to limited assurance reviews by the Audit and Risk Committee, including presentation of the action plan to the Audit and Risk Committee by the Executive Lead Director. The internal auditor takes a risk-based approach to formulating the annual work plan for agreement with management prior to final approval by the Audit and Risk Committee.

External audit provides independent assurance on the Annual Accounts, Annual Report and the Annual Governance Statement.

Significant internal control issues:

Gaps in internal control or assurance which arise during the year are identified in a multitude of ways as a result of the effectiveness of our internal controls; three principle ways that any such gaps are captured and reported are through the Business Assurance Framework, Risk Management Framework and audit, both internal and external. Such gaps are identified and corresponding actions are set and managed

Notable matters which impacted on the effectiveness of our internal controls and commentary on corresponding actions taken, which arose during 2022/23 are summarised below:

- The Trust outsources elements of its transactional financial services to two third party suppliers namely NHS Shared Business Services (SBS) and the NHS Electronic Staff Record (ESR) Programme. Assurance on the effective operation of the control environments with these suppliers is gained through various measures, including independent auditors' reports. The national independent audit on the NHS Electronic Staff Record Programme for the period 1 April 2022 to 31 March 2023 has received a qualified opinion. The Trust is satisfied that there are compensating controls at the Trust that are sufficient to mitigate the control deficiencies with the third party and is furthermore assured by the additional procedures performed and conclusion reached by external audit.
- The Head of Internal Audit opinion report noted the following audits as having received Limited assurance:
    - Emergency Preparedness, Resilience and Response (EPRR) – Post Incident Debriefs
    - Medical Staffing – New L2P Job Planning System – Progress with Project
    - Workforce Plan and Ongoing Workforce and Workforce Planning Considerations, Split Opinion (Limited and Satisfactory)
    - Medical Devices Training Records
    - Completion of Risk Assessments on Admittance to Hospital

These audits have been considered by the Audit Committee and detailed action plans have been identified. These are being reviewed and monitored during 2023/24 by the Audit Committee (reporting to the Board of directors). In addition, the Executive leads, as well as Team as a whole, are reviewing operational progress routinely.

## Conclusion

In concluding my review on the overall system of internal control, I am assured that:

- the Board, Executive Directors, senior management and staff of the organisation, have identified and are managing the risks we face, with escalation of risk events, an effective process for keeping risk scores up to date and flagging any risk and control concerns
- there is an appropriate risk management framework embedded in the organisation along with there being no major concerns from the undertaking of an effective programme of independent, risk-based monitoring
- our internal auditors and other independent assurance providers such as external auditors, have no major concerns from their risk focussed programme of independent assurance.

My review therefore confirms that no significant internal control issues have been identified for the financial year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Liz Davenport, Chief Executive

28 June 2023

## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS OF TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Liz Davenport, Chief Executive

28 June 2023

David Stacey, Chief Finance Officer

28 June 2023

## Appendix A – Biographies of the Board of Directors as at 31 March 2023

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| **Richard Ibbotson**<br>**Chairman**<br><br>**Appointed:**<br>**June 2014**<br><br>**Reappointed:**<br>**April 2017**<br>**June 2020**<br>**June 2021**<br>**March 2022**<br>**March 2023** | Sir Richard Ibbotson was appointed as Chair in June 2014, shortly after retiring from a career in the Royal Navy. This included periods in command of Britannia Royal Naval College Dartmouth, Commander British Forces Falkland Islands and Deputy Commander-in-Chief Fleet (effectively Chief Operating Officer of the Royal Navy and Royal Marines). He has considerable experience in operating at Board level and dealing with operational pressures and challenging budgets.<br><br>As well as being knighted for his services, Richard is a Companion of the Most Honourable Order of the Bath and holds the Distinguished Service Cross and the NATO meritorious service medal. His academic background includes a degree in chemistry, a master's degree in defence technology, and an honorary doctorate in technology. He also holds other public roles, notably as a Deputy Lord Lieutenant for Devon.<br><br>Richard has been a Governor of Plymouth University and Chairman of the Royal Navy Royal Marines Charity and was a Member of the Armed Forces Pay Review Body.<br>Richard is Chair of the Council of Governors, the Non-Executive Nominations and Remuneration Committee and the Governor Nominations and Remuneration Committee. |
| **Liz Davenport: Chief Executive**<br><br>**Appointed:**<br>**October 2018** | Liz as Chief Executive is responsible for the overall management of Trust activities delivering high quality services to the standards set within the resources available. As Accountable Officer she is responsible for ensuring that the Trust meets all of its statutory duties.<br>Liz started work in the Trust in Torbay in September 2014 and was appointed as the Chief Operating Officer for the Integrated Care Organisation in January 2015. She took a key role in leading the implementation of the integrated care model, including the development of community services. Liz was appointed in October 2018 as the Trust's substantive Chief Executive following a period in the Interim role.<br>Liz has a clinical background, and has been employed in the NHS since qualifying in 1986 as an Occupational Therapist. She has a passion for service improvement and transformation designed to improve outcomes and experiences for people in our communities making the best use of resources and evidence of what works well. Her career started in mental health services where she was involved in the setting up of community services for people with mental health needs. She has subsequently continued to work in a number of NHS organisations across the country leading on a number of service improvement projects in mental health, learning disabilities and social care services. She has also held a broad portfolio of Executive Director positions including Director of Operations, Director of Workforce and Organisation and Deputy Chief Executive in Devon Partnership Trust before making the transition to Acute and Community services in Torbay. |

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| **Chris Balch**<br>**Non-Executive Director**<br><br>**Appointed:**<br>**April 2019** | Chris Balch joined the Board as Non-Executive Director in April 2019. Chris is Emeritus Professor of Planning at Plymouth University and is a Chartered Town Planner and Surveyor. Prior to his academic career he held senior executive positions with an international property advisory company, latterly as Managing Director of DTZ UK & Ireland, now part of Cushman & Wakefield. He has extensive experience of providing consultancy advice to public and private sector clients across the UK and overseas specialising in the planning and delivery of major regeneration projects and programmes.<br>He has been Chair of Basildon Renaissance Partnership, a member of the Council of Essex University, a Director of Torbay Development Agency and Non-Executive Chairman of Hilson Moran, a consultancy specialising in the energy performance of complex buildings. He is currently a member of the Supervisory Board of Ecorys BV, a European policy and research consultancy and is a Trustee and Vice-Chair of South West Lakes Trust. He is Independent Advisor to the Development Committee of Live\|West and will join the Board of LiveWest from September 2023.<br>His interest lies in tackling the underperformance of places and managing positive change within professional organisations and communities.<br>Chris is Chair of the Building a Brighter Future Committee (previously known as the HIP2 Redevelopment Committee). He is also a Board member and Chair of the Trust's subsidiary SDH Innovations Partnership LLP. |
| **Jacqui Lyttle**<br>**Non- Executive Director and Senior Independent Director**<br><br>**Appointed: October 2014**<br><br>**Reappointed: October 2017**<br>**October 2020**<br>**October 2021**<br>**October 2022** | Jacqui Lyttle joined the Board as a Non-Executive Director in October 2014 having spent over 20 years working in the NHS at very senior manager and executive board level before establishing her own healthcare consultancy in 2008. She has a genuine passion for improving care for patients and speaks both nationally and internationally on quality and service improvement, commissioning for outcomes and the management of change within healthcare.<br>Jacqui has an interest in the management of pain and is an executive member of the Chronic Pain Policy Coalition a standing committee of an all Parliamentary Party Advisory Group. Other areas of interest include rheumatology, dermatology, endocrinology, cardiology and oncology with Jacqui working extensively in these areas across the UK<br>Jacqui continues to work actively within the NHS, undertaking service reviews and leading on large scale quality improvement programmes and acts as an executive commissioning advisor to several Royal Colleges and health related charities including Action on Pulmonary Fibrosis, Neuroendocrine Cancer UK and Diabetes UK. Jacqui is a lecturer on the NHS for Health Education England and has a keen interest in developing future clinical leaders.<br>She is also an NHS advisor to several professional bodies including the British Society for Rheumatology and the British Association of Dermatology. Jacqui is Chair of AGE UK Torbay.<br>Jacqui is Chair of the Quality Assurance Committee and the Torbay and South Devon NHS Charitable Funds Committee and is the Trust's Senior Independent Director. |
| | Vikki Matthews joined the Board as Non-Executive Director in December 2017. She is currently the Executive Director for People and Culture at Health Education England, prior to which she was the Executive Director for People and Comms at South Western Ambulance Service. Previously she ran her own coaching and consulting business. She was also the Chief Talent Officer for Plymouth University and held several Global and EMEA-wide Director level roles for Nike based in Holland and the USA. |

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| | Vikki Chaired a Multi Academy Trust based in Plymouth from 2012-2017 and is currently the Company Secretary for a small education charity in Brighton.<br>Vikki is Chair of the People Committee |
| **Paul Richards**<br>**Non- Executive Director**<br><br>**Appointed: November 2017**<br><br>**Reappointed:**<br>**November 2020** | Paul Richards joined the Board as a Non-Executive Director in November 2017.<br>Highly experienced at Board level in both public and private sector organisations, Paul applies strategic insight and constructive challenge on complex organisational issues and drives improvements in performance and outcome. He has been director and SRO for numerous Programmes in the EPR and Clinical Systems space ranging from design, build, test and through to implementation and benefits realisation. He has been a leader of several major international EPR and clinical supplier companies and within large professional services organisations and has worked extensively internationally.<br>Paul has a strong track record of leading multiple large, technology based/digital businesses to sustainable growth and success through working in partnership with stakeholders and boards in a variety of board roles. He has decades of experience working internationally, across the private and public sector and has repeatedly been called in to bring in new ways of working, governance arrangements and renewed focus. Throughout his career Paul has served on the European HIMSS Governing Council, TECHUK (formerly INTELLECT) Health Council, he is a Fellow of: the British Computer Society (FBCS); the Royal Society of Arts (FRSA); and the Institute of Directors (FIoD).<br>Paul has a passion for improving and connecting health and social care though digital adoption and health tech and the benefits these solutions bring to clinical outcomes, the patient and service user experience and to clinicians and carers. He continues to have a variety of business interests.<br>Paul is a Chair of the Torbay Pharmaceuticals Board and a member of the Building a Brighter Future Committee. |
| **Robin Sutton**<br>**Non- Executive Director**<br><br>**Appointed:**<br>**May 2016**<br><br>**Reappointed:**<br>**May 2019** | Robin Sutton joined the Board as Non-Executive Director in May 2016. Robin is a Chartered Accountant with over thirty years of financial experience gained at a senior level for both private and public enterprises in both executive and Non-Executive Director roles. Robin has previously held Non-Executive Director and senior positions at several multi-national organisations including Sifam, JDS Uniphase, CompAir Holman, Rolls-Royce PLC and Deloittes.<br>Robin's interest in healthcare stems from a variety of different factors, ranging from consulting for Lowell General Hospital in Massachusetts through to working with Novartis in developing ultrafast fibre laser technology for eye surgery. He has also been heavily involved with care services and social care covering a spectrum of services from meals on wheels, day care, supported living and residential care. Robin currently has local business interests in the care industry and is the Chair of Devon Care Homes Collaborative.<br>Robin has also enjoyed completing an Innovating in Healthcare program with Harvard University with a team of like-minded people looking at smart phone applications in the field of dementia. Robin is Chair of Audit Committee, Non-Executive Director of Torbay Pharmaceuticals and a Director of the Trust's subsidiary SDH Developments Limited. |

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| **Siân Walker-McAllister**<br>**Non-Executive Director**<br><br>**Appointed:**<br>**September 2022** | Siân Walker-McAllister joined the Board as a Non-Executive Director in September 2022. Siân is an independent social care consultant, a Registered Social Worker, and an Associate of the Association of Directors of Adult Social Services. A former local authority Director of Health & Social Care, Siân has over 40 years' experience of working in social care in London, the South-West and in Wales.<br>As a former Housing Association Director, Siân was responsible for the delivery of a wide range of commissioned social care services as well as supported housing in London and the south-east and in Devon. Alongside her role as a Non-Executive Director with us, Siân currently chairs two Safeguarding Boards in the south-west region, and co-chairs the National Safeguarding Adult Board Chairs' Network.<br>Siân is concluding two terms of office as a Commissioner for the Jersey Care Commission in 2023. Siân has a wealth of experience of non-executive director roles across a local authority, the NHS, Housing Associations, and the voluntary sector.<br>Siân is driven by a passion for excellence, ensuring all services to vulnerable people are person-centred, easy to access and importantly promote independence, while ensuring people are safe. |
| **Richard Crompton**<br>**Non-Executive Director and Vice Chair**<br><br>**Appointed:**<br>**August 2022** | Richard joined the Board as a Non-Executive Director in August 2022. Richard was a police officer for 32 years beginning his career in the Metropolitan Police. He served for 19 years in Devon and Cornwall holding various ranks in Plymouth, Torbay and Exeter. He transferred to Cumbria Constabulary in 2001 before moving to Lincolnshire Police as Deputy Chief Constable and later as Chief Constable. Richard held national responsibility for policy in relation to Vulnerable Adults, Vulnerable and Intimidated Witnesses, Wildlife and Environmental Crime, and for Neighbourhood Policing and Partnerships. He chaired the East Midlands Association of Chief Police Officers leading a major programme of collaboration across the five forces. In August 2012 on retiring from policing Richard was appointed chairman of University Hospitals Plymouth NHS Trust and served in that capacity until July 2022. He has also chaired the Adult Safeguarding Boards of Somerset and Wiltshire, and was the independent chairman of the safeguarding panel for Dimensions. Richard is now a non-executive director on the Dimensions Group Board, and as part of his responsibilities he chairs the Board of Discovery Somerset, a Social Enterprise and Dimensions subsidiary which provides support for learning disabled and autistic adults in Somerset, a national provider of personalised social care services for people with learning disabilities and autism. Partnership working, addressing inequalities and improving services to the most vulnerable have been constant themes throughout his career.<br>Richard is chair of Finance, Performance and Digital Committee and Vice-Chair for the Non-Executive Nominations and Remuneration Committee. |
| **Peter Aitken: Associate**<br>***Non-Executive Director***<br><br>**Appointed:**<br>**January 23** | A medical graduate of the University of Glasgow in 1987 Peter moved to London for post-graduate training at the Royal Free Hospital then St George's Hospital Medical School.<br>He completed vocational training in General Practice and worked as a Primary Care Physician in Accident & Emergency and as mental health adviser to NHS Tooting Walk-In-Centre and NHS Direct Croydon at their inception.<br>Retraining in the psychiatry of general hospital patients he was consultant liaison psychiatrist at St George's Hospital London and University Hospitals Southampton before moving to Exeter in 2002.<br>His career interests are the psychological care of medical patients and suicide prevention. He has published in both fields leading national policy in the design of liaison psychiatry services and |

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| | management of high-risk locations for which he was recognised as 'Psychiatrist of the Year' in 2016.<br>He is Chief Medical Officer at Sussex Partnership Foundation NHS Trust and National Clinical Director for the NHS England DASV Program.<br>He is past Chair, Faculty of Liaison Psychiatry, Royal College of Psychiatrists and previously trustee at Anthony Nolan and member of the steering group for the Zero Suicide Alliance.<br>He is Chair of the RNLI Medical Advisory Committee, mental health adviser to the National Association of Primary Care, trustee at the Lions Barber Collective and He is a practicing Consultant Psychiatrist. |
| **Ian Currie**<br>**Executive Medical Director**<br><br>**Appointed:**<br>**September 2020** | Ian is responsible for provision of high quality, safe and effective care and providing medical input into shaping strategy.<br>Ian joined the Trust in 1998 as Consultant Vascular Surgeon, having previously been Senior Registrar in General and Vascular Surgery at Plymouth Hospitals NHS Trust. Prior to this, Ian worked at several hospitals in the South West, including Cheltenham General Hospital, Bristol Hospitals, Gloucestershire Royal Hospital, as well as John Radcliffe Hospital in Oxford. This period also included a year spent working in Sydney, Australia.<br>Ian has a long-standing interest in integrated care models, urgent and emergency care and elective care, and has held a range of appointments in educational and leadership roles throughout his career. He has a strong interest in prevention and previously developed and led the South Devon and Exeter Abdominal Aortic Aneurysm screening programme. |
| **Adel Jones**<br>**Director of Transformation and Partnerships**<br><br>**Appointed:**<br>**July 2019** | Adel joined the Trust Board in July 2019 and holds the Executive accountability for; the development of the Trust Strategy, the delivery of Improvement and Innovation, both within the Trust and across the ICS and Local Care Partnership, the delivery of the Trust Digital Strategy and the leadership for the Health Informatics Service, Communications and Engagement, strategic partnerships and the delivery of the Building a Brighter Future (New Hospital Programme).<br>Adel has significant experience of large-scale transformational change across health and social care, developing new models of acute and emergency care, integrating health and care services in the community and driving operational efficiency through new ways of working. With extensive experience in strategic planning, workforce re- design, quality improvement and operational management, Adel has worked across many sectors over the last 25 years, including primary care, strategic health authority, acute and community health and care services. Before joining us in 2019, Adel was the Integration Director at the Royal Devon and Exeter Hospital.<br>In leading the digital portfolio, Adel has a keen interest in digital innovation and is joint chair of the NHS Providers Digital Boards Programme and is the Senior Information Risk Owner for the Trust. |
| **Deborah Kelly**<br>**Chief Nurse**<br><br>**Appointed:**<br>**August 2020** | Deborah Kelly is responsible for the quality and safety of the care provided by the Trust, including infection prevention.<br>Deborah joined the Trust in August 2020 and as Chief Nurse leads on several objectives including quality, professional practice, patient experience, safeguarding, and clinical governance. Deborah qualified as a nurse in 1985 and has spent the majority of her career working in London in a range of leadership roles in community, acute and tertiary services. Deborah was previously Deputy Chief Nurse for Barts Health NHS Trust and more recently returned from working in the Middle East as the Deputy Chief Nurse and Chief Nurse for Informatics at Sidra Medicine, Doha Qatar.<br>In her previous roles she has devised quality, clinical governance and patient experience strategies, ensuring that staff and patients |

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| | voice are heard. Deborah feel passionately around creating opportunities to empower staff and has successfully introduced models of shared governance, enabling staff led change and improvement. Her work around patient and public engagement was cited as best practice internationally by the Canadian Agency for Drugs and Technologies in Health 2017 and she has successfully partnered with the Kings Fund in 2015/16 through the Collaborative Pairs Programme. |
| **David Stacey**<br>**Chief Finance Officer & Deputy CEO**<br><br>**Appointed:**<br>**January 2020 (CFO)**<br>**July 2021 (DCEO)** | Dave Stacey is responsible for the Foundation Trust's financial planning and performance, workplace environments and capital & commercial development. He is also the Deputy Chief Executive of the Trust.<br>Dave joined the Foundation Trust in January 2020 from North Middlesex University Hospital, where he spent three years as Director of Finance leading a successful financial turnaround, securing significant external funding for large capital programmes and overseeing a major digital transformation programme.<br>His previous roles include Deputy Director of Transformation at Chelsea and Westminster NHS FT, where he played a pivotal role in the successful integration of West Middlesex Hospital, and Director of Strategy at England's biggest mental health trust, West London Mental Health. Prior to joining the NHS in 2013, he spent 7 years in KPMG's healthcare team, delivering audit and advisory services to a range of UK and international healthcare organisations. |
| **Jon Scott**<br>**Interim Chief Operating Officer**<br><br>**Appointed:**<br>**October 2022** | Jon Scott is responsible for developing, implementing and ongoing oversight of health and social care delivery for our Torbay and South Devon population. He is also responsible for overseeing our health and safety and security management functions.<br>Jon has worked within healthcare systems since 1995. Jon's most recent role was as Chief Operating Officer for the Bristol, North Somerset and South Gloucestershire Integrated Care Board. Prior to that Jon has been a Chief Operating Officer of 17 Acute trusts of all sizes and make-up including Barts Health, Addenbrookes, Portsmouth and Manchester.<br>Jon has a reputation for operational improvement and has worked with teams to win several national awards and been recognised by the Secretary of State for Health and Social Care. Jon is a faculty member of the Institute for Healthcare Improvement and of Deloittes (New Zealand). |
| **Michelle Westwood**<br>**Chief People Officer**<br><br>**Appointed:**<br>November 2022 | Michelle leads the People Directorate and is responsible for the delivery of our People Promise – to build a culture at work where our people feel safe, healthy and supported, and where there is a consistent, compassionate and inclusive leadership and management approach, that is motivating, empowering and encourages accountability.<br>Michelle is a strategic HR leader, with significant knowledge of workforce matters, including introducing new ways of working, leading retention campaigns, and in the development of programmes to support leadership development, capability and organisational culture. She joined us in November 2022, following a 20-year career in the Royal Navy where her last appointment was the Programme Director of the Royal Navy's People Transformation programme.<br>Michelle is deeply passionate about her role and enjoys building and stimulating teams, disrupting the accepted order or status quo to achieve sustainable success for people and organisations. Michelle holds a PhD in personal leadership development, and is a Fellow of the Chartered Institute of Personnel and Development. She also holds Non-Executive Director positions as Trustee of two military charities that aim to support serving military, veterans, and their families, for life. |

| | |
|---|---|
| **Emily Long**<br>**Director of Corporate Governance and Trust Secretary**<br><br>**Appointed:**<br>November 2021 | Emily Long, Director of Corporate Governance and Trust Secretary (non-voting Board member)<br>Emily joined the Trust as Director of Corporate Governance and Trust Secretary in November 2022.<br>Emily is a qualified Chartered Company Secretary and Chartered Legal Executive, specialising in corporate law, corporate governance, organisational structure, stakeholder engagement and risk management. As an experienced dual qualified corporate services professional, Emily brings a wealth of experience having worked in this capacity since 2010 in a number of different sectors: including professional services, aerospace and defence, housing, marine and events. Most recently working for Leonardo, a large international aerospace and defence and supporting the review of their corporate governance, implementing a revised Board and Committee framework, supported by a new delegation's protocol and adoption of a new Code of Governance, the Wates Principles. |
| **Dr Joanne Watson**<br>**Health and Care Strategy Director**<br><br>**Appointed:**<br>**February 2021** | Joanne is responsible for delivering our health and care strategy which focuses on making sure our services meet the current and future needs of our people while supporting them to live well. Her unique Board-level position showcases our innovative approach to providing integrated care and ensuring the best use of the monies we will receive from the Government's New Hospital Programme. We are proud to be one of only 40 recipients of this once in a generation programme which will support us to make a real difference in how we deliver services with, to and for our people.<br>Joanne is also the Director of Infection Prevention & Control. Taking on this role in June 2020, near the start of the COVID 19 Pandemic has required flexibility and the need to make decisions on limited information/ evidence. Our results and outcomes to date compare favourably to the national picture,<br>Joanne joined us in 2016 as Deputy Medical Director and Consultant Physician in Acute Medicine. She is an accomplished medical leader with extensive strategic and operational experience which she has gained over many years as a senior clinician in a range of organisational and system leadership roles.<br>Joanne held a twelve months fellowship working at the world leading Institute for Healthcare Improvement using quality improvement skills gained there in her daily work. She has been instrumental in areas of national policy such as the central role of patient experience and improvement in maternity services.<br>Joanne qualified as a doctor in 1991, graduating from London University. Prior to joining us she was a consultant at Taunton and Somerset NHS Foundation Trust in endocrinology and diabetes. She has held positions with the King's Fund, Royal College of Physicians and the South West Academic Health Science Network. |

## Appendix B – Further information and contact details

To see our annual reports and accounts

You can look on our website www.torbayandsouthdevon.nhs.uk or request a copy by writing to the Foundation Trust Office, Hengrave House, Torbay Hospital, Torquay, TQ2 7AA. Large print or other formats are available on request.

To obtain additional information available under the Freedom of Information Act, refer to our public website at www.torbayandsouthdevon.nhs.uk For information not available on our public website, contact the Freedom of Information Office at Torbay Hospital on 01803 654868 or email dataprotection.tsdft@nhs.net

To hear more

During the COVID-19 pandemic, we have been holding all corporate meetings, including Board meetings and Council of Governors' meetings virtually. Once the government guidelines for the NHS enable us to meet in person we will revert to holding meetings in public. In the meantime, the public can access recordings of our Board meetings via our website.

For further information contact the Foundation Trust office on 01803 655705 or email foundationtrust.tsdft@nhs.net

To tell us what you think

About this annual report or our forward plans, contact the Communications Office on 01803 217398 or email communications.tsdft@nhs.net

To help us to improve our services

There are opportunities offered through our membership, patient involvement, our League of Friends or through donations. Contact:

- Foundation Trust Office on 01803 655705 or email foundationtrust.tsdft@nhs.net
- League of Friends on 01803 654520 or website www.thlof.co.uk
- Torbay and South Devon NHS Charitable Fund (Registered Charity No. 1052232) c/o the Charitable Funds Manager, Regent House, Regent Close, Torquay, TQ2 7AN
- The NHS across South Devon benefits enormously from the work of hundreds of volunteers, giving practical support or fundraising. If you are interested in joining our volunteers, we would welcome your enquiry. Sincere thanks to the hundreds of volunteers who support Torbay Hospital and our community and adult social care services. Contact: Voluntary Services Coordinator on 01803 656272

To complain, seek advice or information about aspects of your care our Patient Advice and Liaison Service (PALS) / Feedback and Engagement Team may be able to assist. Contact: Telephone 01803 655838 | Free phone 0800 028 2037 | Email tsdft.feedback@nhs.net

*To access your health records*

An application form can be obtained for records held by Torbay and South Devon NHS Foundation Trust. You may be charged a fee.

Contact: Data Protection Office on 01803 654868 or email dataprotection.tsdft@nhs.net

To find out about joining our team

As a recruit or returning to work after a break.
Contact: Recruitment on 01803 654120 or email tsdft.workwithus@nhs.net

For work experience placements

Contact: email tsdft.workwithus@nhs.net

For general health queries

Contact NHS advice by telephone on 111

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## FOREWORD BY THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome to our Annual Report for 2022/23. As we look back on another challenging year for the NHS, we are hopeful for what the future may bring for our people and our communities.

As the largest employer in Torbay and South Devon we take our role as an anchor institution very seriously. We are much more than the services we provide~~ – ~~, delivering better health and care for all encompasses not only ~~our~~the provision of clinical services, but in acknowledging our role ~~as an employer caring for our people~~within the locality and ~~offering~~communities we operate within; both economically and environmentally. Not only are we able to offer local people opportunities to work with us, ~~our~~but care for the local environment as a significant landowner ~~and our support for~~as well as supporting local businesses through our procurement and purchasing.

Turning to the operational environment we find ourselves within; it is over three years since the World Health Organisation declared COVID-19 a pandemic and during that time the NHS has been challenged as never before in its 75-year history. One of the outcomes of COVID-19 has been the delay of service delivery in some areas~~, leading~~. This has led to longer waiting lists for care and treatment, which combined with a tired workforce~~, has created challenges. But it~~ has ~~also~~been challenging. This has however encouraged us to consider new ways of working, pushing us to be more innovative and creative. It has also given us moments of joy~~ as ~~, encouraging communities ~~have~~to come together to care for ~~each other, to~~and support each other ~~and~~as well as creating opportunities for us to deliver care in different ways, improving experiences and outcomes.

During the year we were placed in segment 4 of the system oversight framework (SOF) set by NHS England~~; which is the~~, our regulator and operating licence issuing body. This framework ~~that~~ prescribes their approach to regulatory oversight and intervention dependent on financial and operational performance. All acute providers in Devon and the Devon system ~~as a whole~~ are currently in segment 4 as a result of our financial and operational performance challenges. We are committed to working together with our people to address our challenges and to deliver better care and better value for our communities.

Noting the above, over the past twelve months we have however witnessed emerging signs of recovery in our services, our teams and our people. Our highlights this year ~~include~~included the opening of our new Acute Medical Unit at Torbay Hospital, which is helping to transform how we provide urgent and emergency care. Thanks to the generosity of our Brixham Hospital League of Friends, our GP partners are ~~providing~~now able to provide primary care services from the hospital site, with the opening of branch surgeries~~, and we are looking forward to ~~. We also saw the ~~opening~~progress toward completion of the new purpose-built health and wellbeing centre in Dartmouth; which has since opened, with a successful launch event in May 2023.

Many of the challenges we face are not unique. Working together with our health and care partners in the Devon and Cornwall peninsula is key to us providing better health and care for all, ensuring that everyone has access to the care they need,

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when they need it. Further detail of our successes and challenges can be found within the Performance report and supporting analysis, pages x to x.

To that end, whilst we have always been committed to partnership working, ~~but~~ this year we have further increased our focus on collaboration within Devon. One example of this is our role within the Peninsula Acute Sustainability programme~~,~~; whose focus is to secure sustainable acute services now and into the future, starting with a review of our fragile services. Together we are working ~~with our partners~~ to ensure that we get the best value for every pound that we spend, while doing those things together that make sense, reducing duplication and waste and enabling us to reduce waiting times and improve patient experience and outcomes.

~~We continually strive~~As an organisation we are committed to ~~improve~~improving and ~~deliver~~delivering excellent, high quality, safe care to people who use our services~~, in partnership with them.~~. We passionately believe that the best way to care for people is by ~~focusing~~focussing on what matters to them, empowering them in their own care and integrating services around them. We believe that care as close to home as possible benefits everyone. This remains at the heart of our vision and our strategy as an integrated care organisation.

We couldn't do any of this without our amazing people. The last few years have taken a toll on all of us, and our dedicated, talented and caring people have experienced significant pressure and stress. We know that people who are fulfilled and valued provide better care and have the energy to develop new ideas and ways of working. Through our people promise, we are working with our staff to create a workplace where each and every one can thrive. We would therefore like to take this opportunity to thank our wonderful people, our volunteers, our governors and members, our many friends from our hospital leagues, nurses' league and other supporters, our fundraisers and our partners. It will take ~~each and every one~~all of us to achieve our vision of better health and care for all, but we believe that we can do this, together.

As we look to the future, we plan to continue the positive progress made this year in developing our care model and reducing waiting times across both urgent and emergency and planned care services. We look forward to preparing our Torbay Hospital site for our new hospital and developing our integrated care model. Our new hospital facilities will be supported by local health and wellbeing centres and home-based care, making the most of digital technology to deliver better health and care for all.

Thank you once again for all your support this year and for what we hope will be your continued involvement, engagement and support as we look forward to the next 75 years of the NHS and our brighter future.

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Richard Ibbotson , KBE, CB, DSC, DL Chairman

28 June 2023

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Liz Davenport
KBE CB DS CDL Chief Executive

28 June 2023 28 June 2023

## INTRODUCTION, PURPOSE AND HISTORY

### Our purpose and activities

We are proud pioneers in integrated health and social care. Our purpose is to support the people of Torbay and South Devon to live well and we aim to achieve this by focusing on excellent population health and wellbeing, excellent experience in receiving and providing care, and excellent value and sustainability.

Improvement and innovation are central to what we do, both in terms of our integrated care services and our specialist clinical services, for example day surgery being nationally recognised for their best practice.

We live and work in a beautiful part of the West Country which is a very popular tourist destination. Our population reflects that of many coastal communities, with a significant level of health inequality and high levels of deprivation. Torbay itself is one of the most highly deprived communities in the south west. The impact of COVID-19 has both increased the pressure across all aspects of health and social care, and increased health inequalities for those who live in our most deprived coastal communities.

We have a low wage and low skill local economy, with a heavy reliance on tourism and not enough opportunities for our young people. Many of our children start their lives at a disadvantage. We have high numbers of looked after children and children with protection arrangements in place.

Poverty and deprivation are key determinants of health and as a result we see significantly more alcohol and self-harm related admissions and poorer mental health and physical health outcomes.

We have a larger proportion of older people than the national average and, due to our area's attractiveness as a retirement location, we expect to see this increase. Many of our older people are living with long-term conditions which results in a greater demand for older people's health and care services, with FEWER young people in our labour market to provide care.

We passionately believe that supporting people to manage their own health and wellbeing is a critical factor in helping them to have better health outcomes and to live well. We do this by focusing on what matters to them and providing personalised, compassionate care as close to home as possible.

We work with many different communities: our patients and their carers, families and friends, our staff, members and governors, care home and domiciliary care providers, our NHS colleagues in Devon and the wider south west as well as colleagues in the private sector, and our public and voluntary sector partners.

Working together, we share and learn from our combined experience and expertise so we can provide the very best care and services for our local people, whenever they need us.

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We serve our local people by providing community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites.

More and more we are delivering care directly into people's homes either through visits or online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in two community locations. Owing to sustained recruitment difficulties, we have had to reduce the number of community sites offering urgent care – this has meant the temporary closure of our minor injury unit in Dawlish. In summer 2022 we were able to reopen our minor injury unit in Totnes which had been closed since March 2020. The urgent treatment centre in Newton Abbot has remained open 7 days a week and offers an x-ray service.

We work in partnership with the communities and the voluntary sector to help people to get home from hospital when they no longer need clinical care and wrap services and support around them to help combat loneliness and isolation and avoid readmission to hospital. We are committed to continuing to support this type of help and will commission a longer-term contract for this type of care and support. In this endeavor, we benefit from the support of 434 active volunteers and work with approximately 89 volunteering for charities.

We support around 300,000 face-to-face contacts with patients in their homes and communities each year and see over 62,459 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

We cover a wide geographical area, including parts of Dartmoor (Newton Abbot, Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes and Dartmouth. We employ over 6,600 staff to deliver and manage our services, from porters to consultants, nurses and health care assistants to 'hotel' and catering staff, therapists and security staff….and there are many more! We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

Our operating income for 2022/23 was £644 million. NHS Devon commission our main acute and community services. Devon County Council and Torbay Council commission our adult social care services and our public health nursing services. We have continued to forge many strategic and business partnerships to strengthen and improve our services as detailed below:

- we are the lead organisation in the alliance with Devon Partnership Trust, through which we provide Children and Family Health Devon (CFHD) since April 2018. Our other alliance members are NHS partners Royal Devon University Healthcare NHS Foundation Trust, Devon Partnership NHS Trust and social enterprise Livewell Southwest
- we have a wholly owned subsidiary (SDH Developments Limited) providing an on-site pharmaceutical dispensary at Torbay Hospital
- we are a partner in a Limited Liability Partnership (SDH Innovations Partnership LLP), which supports our ambitions to replace out-of-date facilities with new buildings

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- we are part of University of Exeter's Academy of Nursing, along with other Devon NHS providers
- through Torbay Clinical School, we promote clinical research in partnership with Plymouth University

- more recently, we became a partner in the Peninsula Acute Sustainability Programme (PASP) with University Hospitals Plymouth NHS Trust, Royal Devon University Healthcare NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust which supports us to collaborate to secure sustainable, high-quality care for everyone for the future
- in 2021, we became a core part of the South Local Care Partnership with our NHS, council and voluntary sector partners. There are five local care partnerships across the county which form a key part of the Devon Integrated Care System
- we are continuing to forge closer partnership with South Devon College to align our workforce and education strategies.

Looking ahead, we have been given a share of £20 billion government funding for a new hospital development. This is a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people. It is not just about building a better hospital in Torquay. It is about building a brighter future for all of us.

We are exploring opportunities to deliver our services in ways that provide better outcomes for our population and better working environments for staff across all the communities that we serve and further building on our integrated approach to service delivery, led and shaped by our health and care model.

## Our history and statutory background of the Foundation Trust

Torbay and South Devon Foundation Trust ("the Foundation Trust or Trust") was established as a public benefit corporation and integrated care organisation, following its approval as an NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts authorised under the Health and Social Care (Community Health and Standards) Act 2006 on 01 October 2015.

The principal location of the business ~~of our organisation~~ is Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA. Our licence registration number with NHS England is: 110102

In addition to the above, we have registered the following locations with the Care Quality Commission:

- Ashburton and Buckfastleigh Hospital, Eastern Road, Ashburton TQ13 7AP
- Brixham Hospital, Greenswood Road, Brixham TQ5 9HN
- Brunel Dental Centre, Brunel Industrial Estate, Newton Abbot TQ12 4XX
- Castle Circus Health Centre, Abbey Road, Torquay TQ2 5YH
- Dartmouth Clinic, Mayors Avenue, Dartmouth TQ6 9NF
- Dawlish Hospital, Barton Terrace Dawlish EX7 9DH
- Kingsbridge Hospital (South Hams) Special Care Dental, Plymouth Road, Kingsbridge TQ7 1AT

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- Newton Abbot Hospital, Jetty Marsh Road, Newton Abbot TQ12 2TS
- Paignton Hospital, Church Street, Paignton TQ3 3AG
- St Edmunds Victoria Park Road, Torquay TQ1 3QH
- Tavistock Special Care Dental Service, 70 Plymouth Road, Tavistock PL19 8BX
- Teignmouth Hospital, Mill Lane, Teignmouth TQ14 9BQ
- Torbay Hospital, Newton Rd, Torquay TQ2 7AA
- Totnes Hospital, Coronation Road, Totnes TQ9 5GH
- Walnut Lodge, Walnut Road, Torquay TQ2 6HP

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We are registered with the Care Quality Commission without conditions and provides the following regulated activities across the stated locations:

- assessment or medical treatment for persons detained under the 1983 Act
- diagnostic and screening procedures
- family planning services
- 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.

As a Foundation Trust responsible for public funds, the Board of Directors is accountable to a range of stakeholders and crucially the local people that use our services. Our local population ~~are~~is formally represented within our governance structure by the Council of Governors. Governors are elected from each constituency, with the number of positions weighted by the population living in the locality. Full guidance on how Foundation Trusts are required to operate is available from NHS England.

## Our values and the NHS Constitution

At our core, we are deeply connected to, and rooted in, the values of the NHS. We work together for patients and our communities.

We have adopted the NHS constitution values which apply across the NHS in England. Patients, public and staff developed these together. Our shared NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Our values are:

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- working together for people
- everyone counts.

Our people promise is our commitment to each other, including how we enhance our own behaviours which will help us demonstrate and deliver the NHS values. We know that a good staff experience leads to a good patient experience, and our people promise is a framework to ensure every aspect of our experience working in the NHS is nurtured. By looking after our staff, we continually work to ensure our values are upheld.

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Our people promise priority is to build a healthy culture at work where our people feel safe, ~~health~~healthy and supported~~. Our~~, in order to achieve all the different components of the NHS people ~~promises are~~promise :

- we are a team
- we are safe and healthy
- we are compassionate and inclusive
- we each have a voice that counts
- we work flexibly
- we are always learning
- we are recognised and rewarded.

To deliver our People Promise, we are focusing on designing a consistent, compassionate leadership approach that is inclusive, motivating and empowering; creating an environment of kindness and respect; and making people's lives easier by freeing up time to work in a safe and calm manner on agreed priorities.

Our People Awards are based on our people promise, recognising and rewarding our people for living our people promise and our values.
Our people promise and values ~~make us great people~~underpin how we want to work ~~with, and by working~~ together, by doing so we can support better health and care for all.

## Our partners

Our purpose to support the people of Torbay and South Devon to live well is delivered in partnership with local organisations and communities. We do this by working with our South Local Care Partnership (LCP) and across our wider Integrated Care System, with health and care providers across Devon.

At a local level we have strong relationships with our local GPs and primary care, Devon County and Torbay Councils, the local community voluntary sector and our independent sector partners who provide much needed care home support and domiciliary care. We work closely with our local councils and the business community to improve the wider determinants of health and recently signed a memorandum of understanding to be an active partner in community wealth building.

We are clear about our leadership role in our local health and care system. As an anchor institution we are deeply connected to our local area and we use our influence, skills and resources to benefit the communities we serve.

We recognise the challenge of both maintaining and developing our own organisation while contributing and collaborating to improve the health and wellbeing of everyone, not only in Torbay and South Devon but in the county of Devon as a whole.

## Integrated Care System – the Devon long-term plan

NHS Devon (the integrated care board) ~~is currently developing~~has developed its Joint Forward Plan (JFP) in collaboration with the five local care partnerships and three health and wellbeing boards in the county.

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The plan, which is to be submitted by June 2023, will set out how the system will work together~~ in a different way~~, to deliver transformational change and improve the health and wellbeing of the population.

It includes nine areas of focus:

1. primary and community care
2. mental health, learning disabilities and neurodiversity
3. women and children
4. acute services
5. housing
6. community development
7. employment
8. health protection
9. suicide prevention

The JFP is a response to the Integrated Care Strategy, which was published in draft on the One Devon website in January 2023. NHS, local authority, and other partners were all involved in producing the strategy which was coordinated by the One Devon Partnership (the integrated care partnership).

The Devon system is currently in level four of the System Oversight Framework (SOF4) due to finance and performance issues, which brings with it enhanced direct oversight by NHS England and additional reporting requirements and financial controls. The JFP therefore reflects the need to focus on system recovery and exiting SOF4 as priority.

A summary of the SOF4 exit criteria are listed below, with an estimated exit date of 2024/25:

- urgent and emergency care – make progress against national objectives
- elective recovery – make progress against national objectives
- finance – develop and deliver realistic balanced plan for 2023/24
- leadership – demonstrate collaborative decision-making
- strategy – deliver phase one of the Peninsula Acute Sustainability Programme (PASP).

Partners across the county continue to work together in many areas, including the PASP. PASP sees clinicians and staff from across Devon, Cornwall and Isles of Scilly working together to ensure the clinical, workforce and financial sustainability of acute services.

A series of workshops have been underway since December 2022 to review and redesign acute services, initially beginning with paediatric assessment, medical assessment, and surgical assessment.

# Part I –PERFORMANCE REPORT, OVERVIEW, RISK & ANALYSIS

## PERFORMANCE OVERVIEW & RISK POSITION

### Summary of our performance

The purpose of this section is to provide information about our organisation, our purpose and main objectives, the key risks to the achievement of our objectives, and how we have performed during the year. More detailed information on the arrangements in place and our approach to ensure services are well-led is given in the Performance Analysis Report and the Annual Governance Statement.

In this section, we highlight the main developments ~~to~~in our services and the improvements we have made over the past twelve months. We also report our performance against key national and locally determined clinical standards.

This report outlines our position ~~as at~~on 31 March 2023 and provides commentary on relevant post year-end matters.

### Chief Executive's statement on performance

The pressures of meeting the health and social care needs of a growing and diverse population, alongside ~~great~~large changes to the infrastructure of the NHS, in a difficult financial climate have been significant; as you will see within our performance data, which shows both our challenges and our emerging signs of recovery. Our performance is assessed against a range of national targets and standards and is reported externally.

With regard to National priorities, these are outlined in the ~~2022/23 operational planning guidance~~ 2022/23 operational planning guidance and include: investing in the workforce, responding to COVID-19 ever more effectively; delivering significantly more elective care to tackle the elective backlog; improving the responsiveness of urgent and emergency care (UEC) and building community care capacity; improving timely access to primary care; improving mental health services and services for people with a learning disability and/or autistic people; continuing to develop our approach to population health management, preventing ill-health and addressing health inequalities; exploiting the potential of digital technologies; making the most effective use of our resources; and establishing ICBs (Integrated Care Boards) and collaborative system working.

An assessment of our progress against these, and performance more generally, can be found within the Performance report and supporting analysis, below. Supporting analysis and commentary are provided with trend charts showing the position over the previous five quarters or fifteen months, depending on the frequency of the measurement period.

For their oversight and assurance during the year, the Board of Directors considered an Integrated Performance Report at each meeting which described performance against these targets and any action being taken to address dips in performance. This is informed by detailed review at Executive, Care Group and Committee level prior to each Board meeting.

In addition, the Integrated Service Units ('ISUs'), each of which is responsible for delivering services to their localities (Coastal, Moor to Sea, Newton Abbot, Paignton and Brixham, and Torquay) reviewed quality and performance dashboards relevant

to their services ~~on a~~ monthly ~~basis~~ and to present plans where there were risks or concerns. There was also detailed scrutiny of the different elements of the Integrated Performance Report through the Finance, Performance and Digital Committee, People Committee and Quality Assurance Committee. At each financial quarter end, the Board confirms the position of each of these metrics to NHS England. Details of our performance during the year can be seen below.

## PERFORMANCE OVERVIEW CONTINUED: OUR HIGHLIGHTS, OUR CHALLENGES & RISK PROFILE, OUR SUCCESSES, OPPORTUNITES & OUR KEY EVENTS

Below is a summary of our highlights and risk position, noting our challenges, our opportunities and context within the Devon locality.

### Our year in highlights 2022-23

It has been another tough and challenging year. We have experienced sustained demand for services whilst managing a challenging landscape for delivery, which has been impacted by COVID-19 as well as those who sought treatment delayed due to the pandemic, seasonal illnesses and industrial action by NHS and other public and private sector workers. Through the commitment of our people and a focus on driving improved performance we are, however, seeing signs of recovery with a reduction in the length of time people are waiting for treatment; although there is still a ~~very~~ long way to go to ensure people are seen as quickly as we would wish.

Partnership is and remains central to our ethos; both as an integrated care ~~organsation~~organisation and committed partner within the Devon Integrated Care System. You will see this as a key theme when describing our performance and service improvement measures taken during this and into the next financial year. Our dedicated people have been central to this as well as those working across NHS Devon and our key stakeholders; whose approach to collaborative working has provided a real opportunity to listen, learn and help us scope delivery for our vision of better health and care for all.

Despite the progress we have made, during the year,we were placed in segment 4 of the system oversight framework (SOF) by NHS England. All acute providers in Devon and NHS Devon are in segment 4 ~~as a result of~~due to our financial and performance challenges. We are working together with our system partners to:

- improve how we deliver care, in line with best practice and the latest evidence
- improve our levels of activity so fewer people ~~have to~~ wait for care
- make sustainable, affordable improvements that put us in the best position to secure the investment we need to continue to deliver better care
- deliver the best value we can to our people and communities while managing our available monies effectively and balancing our books.

We have developed a clear plan that will support us to deliver the level of improvement required to move from SOF4 to SOF3 by the end of 2023/24, in the hopes that this will support the system ~~as a whole~~ to move out of SOF4. Our aim is to deliver safe, sustainable, and affordable services that provide the best care, outcomes, and experiences we can. We want to deliver the best value we can while supporting our people to deliver care they can be proud of and providing a great place to work.

## Our challenges and risk profile

Our primary challenges and key risks are derived from our financial position, the delipidated state of our physical and digital environments, the quality of services we provide, maintaining our workforce and caring for our people (reducing turnover).

The oversight and management of these is reflected in our business assurance framework which allows us to distill our strategy into key themes (objectives) and manage our risk to delivery, monitoring any gaps in assurance that we will deliver as well as our corporate risk register.

A summary of the challenges we faced in 2022/23, going into 2023/2024 ~~,~~can be found below:

- delivery of a challenging financial plan, including significant savings and productivity initiatives while maintaining a personalised and safe patient experience for all of our users:
  - recovery of activity levels to pre-pandemic levels and beyond, managing and reducing increased waiting lists
  - delivery of an ambitious capital programme
  - challenged workforce capacity and resilience, burnout/fatigue arising from ongoing significant operational pressures risk of lack of talent pipeline and supply, recruitment and retention of staff across specific specialties/professional groups, due to no strategic business or workforce planning
  - creating capacity for learning and development opportunities for our leadership teams and people in general due to the workforce capacity and resilience matters outlined above
  - risk of unaffordable workforce costs due to increased use of bank and agency staff
  - risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
  - risk of inability to build a culture where people feel safe, healthy and supported due to rising number of equality, diversity and inclusion (EDI) related grievances and a reported decline in workplace experience by those with disabilities or from a BAME background.

A detailed analysis of these and our risk management framework can be found within the Annual Governance Statement, pages x to x

## Our successes, priorities and opportunities: strategic delivery

This annual report (year ended March 2023) aligns to the revised strategy adopted by the Board in February 2022, which is reviewed annually. Key activities aligned to our six strategic priorities and intent ~~is summarised below.~~are:

### Providing more personalised and preventative care: what matters to you matters

An innovation grant awarded for Multiple Sclerosis (MS) augmented reality project ~~We are developing pioneering technology to help~~ to support people ~~living with MS manage their condition from the comfort~~with multiple sclerosis to take care of their ~~home.~~

~~Our MS augmented reality (AR) clinic allows people living with MS and our clinicians to talk to each other remotely using Microsoft HoloLens 2 AR headsets. People living with MS can talk and interact with holographic objects by wearing the AR headset which helps our clinicians to assess them and gather important information about their condition.~~

~~In November we received a £402,000 grant to co-develop a software application for AR glasses to improve motor function assessments of people with MS. We hope that this may prove to be a gamechanger in how people with long-term conditions or those who are immunosuppressed will be cared for in the future.~~
~~Using the experience of people living with long-term~~ health ~~conditions to help others~~.

We ~~further~~have expanded our Health Connect Coaching programme to ~~empower more people with~~ match volunteer coaches who have lived experience ~~of a~~with long - term ~~health condition~~conditions, to ~~support~~help others ~~to manage their health and wellbeing.~~

~~We carefully match patients with a trained volunteer coach who has the same or a similar health condition. Over a six-month period, they help them~~ to take control and ~~build their confidence to manage their health in a way that matters to them. We're currently supporting people living with multiple sclerosis, chronic pain, rheumatological conditions, fibromyalgia, neurological conditions or a stoma to support others. The feedback we are receiving from both coaches and those being coached is really positive and demonstrates that both parties find the experience really valuable and helpful.~~manage their own health

## Reducing inequity and building a health community with local partners

~~Supporting people affected by the cost of living crisis~~
Our Torbay adult social care service ~~have~~ worked with the voluntary sector to ~~create a voluntary sector procurement alliance to agree how we can use allocated money including the adult social care precept to help it reach the people who need it the most.~~
~~The alliance completed a procurement process to~~ provide support to address the ~~impacts~~ impact of the cost-of ~~the cost-of-living crisis and awarded £500,000 across eight local voluntary sector organisations.~~
~~This money has been used to:~~

- ~~to support people to manage~~-living crisis. Support includes debt ~~and income~~
- management, access to energy advice
- ~~discover~~, employment opportunities

~~develop~~ and access to community-based support ~~projects.~~ .

Increasing our fundraising activities to support treatment and care

~~These schemes will run from 2023 to 2025 and will enhance the voluntary sector offer locally.~~

~~Eleven-year-old organ donation campaigner made honorary NHS director~~

Health champion Lottie Bryon-Edmond made history when she was made an honorary director of our Board in recognition of her commitment to raising awareness of organ donation and the life-changing contributions of donors and their families.

~~Lottie, 11, received a liver transplant when she was just five weeks old making her, at the time, the youngest person in the world to successfully receive a liver transplant.~~

As well as raising awareness of organ donation, Lottie is tirelessly fundraising for a permanent memorial for organ donors and their families which we hope will be installed in the main entrance of Torbay Hospital ~~in the not too distant future.~~ soon.

~~Increasing our fundraising activities to support treatment and care~~

Donations to our charity have once again helped to improve and enhance patient care, funding equipment and projects that are over and above those provided by NHS funding.

~~We've used the donations to purchase a range of items including scalp cooling machines for people being treated for cancer, and a maternity twin cot which is being used on our special care baby unit to help keep families together.~~

~~Thanks to people's generosity we have also used charitable donations to support people in non-clinical ways, such as offering free of charge weekly yoga sessions to patients following breast cancer treatment.~~

We reiterated our commitment to working alongside local, regional, and national fundraising and charitable organisations to, wherever possible, maximise the opportunities to bring in monies that will benefit our local people and communities.

## A relentless focus on quality improvement underpinned by people, process and technology

### Emergency department improvements welcomed

~~We are aware that coming to~~ **The Emergency Department** ~~(ED) can be an overwhelming experience either as~~**team have had a real focus on quality improvement, developing a patient** ~~or supporting a loved one as they wait in unfamiliar surroundings. Based on what people told us, we made significant improvements to the waiting area to help them understand what to expect while waiting to be seen.~~

~~A new patient~~ journey map ~~welcomes~~to welcome people at the main entrance and in the triage area ~~to explain~~. The map explains what to expect when ~~they~~patients arrive in ED, the assessment process (based on the urgency of their symptoms or injury) and any required care and treatment they may need. We also installed new signage to direct people to the treatment areas, a TV screen showing information such as waiting times and a graphic showing the range of uniforms worn by different ED staff.

The changes, which are part of a wider patient improvement project to improve people's experiences at the hospital, have been welcomed by our people and visitors.

### Revolutionary radiotherapy trial for people with throat cancer

During the summer we opened a clinical research trial called TORPEdO, where throat cancer patients can benefit from world-class proton beam therapy which uses protons which can release energy at an exact point in the body protecting more healthy tissue and decreases the chance of side effects developing.

Co-led by The Christie NHS Foundation Trust in Manchester and The Institute of Cancer Research in London, this trial will determine whether the use of proton beam therapy reduces long-term side effects and improves the quality of life for people treated with radiotherapy for throat cancer.

Proton beam therapy is currently only available at two sites across the country, but local people taking part in the trial travel to The Christie NHS Foundation Trust for their treatment.

### New virtual tour of neonatal units

We worked with the ~~South West~~Southwest Neonatal Network to create a virtual 360° tour of our special-care baby unit to show parents where their baby will be cared for including the feeding rooms and bedded rooms where ~~they'll~~they will sleep with their child to prepare for their return home. The tour also gives brothers, sisters, and grandparents a chance to see the unit, as well as including messages from parents whose children have been cared for on our unit.

The neonatal network has created a series of videos ~~showcasing~~highlighting the region's other 11 special-care baby units and neonatal transport service to support parents and answer questions, concerns and worries that they may have in a way that is easy to access, so they can focus on caring for their child.

~~Building a healthy culture at work where our people feel safe, healthy and supported~~

### Retaining our people

As a people business, we want to ensure we are providing a great place to work so our people stay and thrive. ~~We're~~We are working with our NHS partners across Devon to make sure our people are happy, healthy, and have opportunities to develop and grow. Our new retention project provides our people with mentoring opportunities to support healthcare staff to feel empowered, supported and listened to with the aim of supporting them to stay in their roles and in the NHS.

Our emergency department has led the way with this work with nurses and their managers having regular career ~~catch-ups~~catchups (also known as stay conversations) to help address reasons why they might want to resign – before they get to that point.

### Horizon Centre redevelopment supports medical student and staff training

Our education and research facility reopened in September after an extensive redevelopment project that will support the training of medical students, multi-professional learners and our people across all our services.

The Horizon Centre is a state-of-the-art environment on the Torbay Hospital site, which hosts many of our education and research initiatives. The works have enhanced the educational and social facilities for both undergraduate learners and the wider staff community.

The redevelopment work cost £660,000 and was funded by the University of Plymouth's Peninsula Medical School. This is in recognition of the increased number of medical students that we now host and will improve their clinical learning and practice experience

### Welcome to our new international doctors

In September we welcomed 18 doctors from Myanmar and India who started their journey to become NHS doctors through the Medical Support Worker programme.

The Medical Support Worker role provides a gateway for international medical graduates and refugee doctors from overseas who come to live and work in England being fast-tracked into the health service and supported to become registered NHS doctors, while working under supervision.

Medical Support Workers already have the experience and training as doctors that, once registered, means they are well placed to apply for training roles in their chosen specialty, more than half of them are now working in a doctor's role for us now having successfully completed the six-month programme~~.~~.

### Improving access to specialist services through partnerships cross Devon

### Devon's Nightingale hospital's legacy continues to support our people

Having played ~~an incredibly important~~a significant role providing emergency in-patient care during the first wave of the pandemic, the NHS Nightingale Exeter, hosted by RDUH, is now host to a range of surgical services & diagnostics which are benefiting our patients and communities.

The Nightingale site has been transformed into a state-of-the-art facility and anyone in Torbay and South Devon needing orthopaedic, ophthalmology, diagnostic and rheumatology services can receive care there.

As an asset utilised and resourced by the whole Devon system it is a shining example of collaborative system working; as such hospital also plays a key role in tackling the region's waiting lists and the extra capacity means that our patients can receive their surgery in Exeter sooner than if they received it at Torbay Hospital.

Local people can also receive their CT scan, MRI, x-ray, ultrasound and fluoroscopy diagnostic services at the Nightingale which complement our scanners and help tackle our waiting lists.

### Improving financial value and environmental sustainability

### Our anaesthetists lead the way in reducing carbon emissions

Our anaesthetists have been working hard to reduce the impact that gases that are used during operations can have on the environment.

Anaesthetic gases are commonly used as part of everyday surgeries and are responsible for more than 2% of all NHS emissions. Carbon emissions for one hour of surgery using Desflurane – one of the most common anaesthetic gasses, but also

one of the most harmful to the environment - is equivalent to driving 189 miles. Lower carbon alternatives produce the equivalent of four to seven miles.

Our anaesthetists have switched to lower carbon alternatives to minimise their environmental impact. This is not only better for the environment, but also has no impact on patient care, their experience or recovery. We have so far saved 844 tonnes of $CO_2$.

### Creating our health and wellbeing centre

In February, we were delighted to welcome Compass House and Mayfield Medical Centre to Brixham Community Hospital with the opening of their branch surgeries.

With financial support from Brixham Hospital League of Friends, patients of both practices can now access appointments with GPs, phlebotomy, nurses and healthcare assistants at Brixham Hospital.

Great progress was made during the year on the construction of the new Dartmouth Health and Wellbeing Centre.

The centre will give people access to a broad range of health and wellbeing services in one place, by bringing together GPs, community nurses, therapists, the voluntary sector (Dartmouth Caring) and a pharmacy under one roof.

### New £15.7million acute medical unit opens

Our long awaited multi-million-pound acute medical unit (AMU) opened its doors in December.

Our AMU is split over two levels and has 36 assessment spaces where patients who have either been referred from our emergency department, from GPs, the community and other specialities can receive a wide range of high-quality care.

The unit is located alongside the emergency department and having the two units side-by-side is already improving the flow of patients across the two departments, allowing for more timely patient reviews and a better patient experience.

Torbay Hospital's League of Friends generously donated more than £500,000 to the project with the funds helping to equip the AMU with new patient trolleys and recliners.

The AMU is the flagship of our building a brighter future programme which aims to make a real difference to how we deliver services with, to, and for our people.

### Funding secured for additional theatres and improvements to endoscopy services at Torbay Hospital

An extra 4,500 people a year needing hip, knee and eye operations will be able to receive their operations at Torbay Hospital thanks to a £15million capital investment to improve services and reduce waiting lists.

The funding is being used to create two modular theatres and additional pre-operative assessment and recovery spaces. The extra theatre capacity will help reduce the length of time local people have to wait for day surgery, and also improve the quality and experience of care.

Meanwhile a £4.99million capital investment has been secured to modernise and increase our Endoscopy facilities. The old building has been demolished and the

new modular facility will create a fourth endoscopy room and a larger training facility which will help increase the numbers of people who can be seen, reducing waiting times and improving experiences and outcomes. Both new developments are due to be completed next year.

## PERFORMANCE ANALYSIS

### Financial position

The financial framework in 2022/23 no longer contained the majority of the income 'top-up' processes that were introduced by NHS England in the financial year 2020/21 and which continued into 2021/22 for the actions needed to respond to the COVID-19 epidemic.

Our financial plan for 2022/23, excluding the net cost of donated income, expenditure and the impact of the year end Buildings and Land revaluation, was to produce a small revenue surplus of £69,000. Delivering this plan required us to produce savings of circa £28.5m and also required us to minimise the impact of inflation on the cost of goods and supplies that we purchase from third parties.

Actual savings delivered during 2022/23 totaled £25.0m, but cost pressures have been substantial and consequently we ended the year with a deficit of circa £17.1m (excluding the net cost of donated income, expenditure and the impact of the revaluation of Buildings and Land).

Inclusive of the net impact of Donated income and expenditure transactions as well as impairments caused through the revaluation of Land and Buildings, our total revenue deficit for the year totaled circa £24.3m as set out in Financial Statements.

Our financial environment for 2023/24 remains challenging. Renewed focus will be required to contain cost pressures and to also to deliver a substantial savings programme of circa £46.6m. After delivery of those savings a planned revenue deficit of £32.6m will be delivered. We will be required to reduce this planned deficit in 2023/24 in subsequent years through further savings programmes.

### Going concern

Our financial statements have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires the Board to assess, as part of the account's preparation process, our organisation's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the trust without transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

### Operational performance

A summary of the key clinical access performance standards used by regulators to assess our performance is set out below for 2023/24 and further analysis can be reviewed within the performance section of the report (page number to be added).

## Urgent and emergency care performance

Along with the wider Devon system, we have been under review from NHS England national and regional teams in relation to ambulance handover performance throughout 2022/23. Moving into 2023/24 we have plans to eliminate handover delays above 15 minutes by the end of March 2024. This improvement in performance will simultaneously contribute to the Devon system position as the Devon system has been placed in Tier 1 monitoring for ambulance handovers.

In relation to the national four-hour standard we have a performance trajectory agreed with regulators that moves us to a position of 76% achievement by the end of March 2024.

We have has made progress against both the ambulance handover delays and four-hour performance in quarter 4 of 2022/23 but will need to consistently sustain improvement throughout the year. In order to provide assurance and progress an Urgent and Emergency Care Board has been established focusing on three key workstream to drive the improvement: emergency department clinical pathways, same day emergency care and flow and ward improvement.

Reducing the number of patients who are medically fit to go home (what we call people with ‘no criteria to reside’) to 5% of the bed base is a further target for next year. We consistently achieved the best performance across Devon during 2022/23 and regularly achieved days of between 5-8% performance. Maintaining and building on this performance as an integrated care ~~organization~~organisation will be key to supporting an improvement in ambulance handover delays and the four-hour standards and as such the target is actively monitored in our Urgent and Emergency Care Board.

In January, part of our Torbay adult social care services, the Technology Enabled Care Service (TECS), launched a new initiative to help with flow through Torbay Hospital. The pilot ran in the discharge lounge and across two wards. People who were waiting in hospital for a care package were shown how to use the technological aids on offer and given a six week trial of the equipment. In its first month, this trial saw 19 hospital bed days saved, a reduction in discharge delays and with all but one patient, a likelihood of a reduction of calls to primary or emergency services. The service is free to the client and is not dependent on meeting eligibility criteria, only that the referrer at the point of discharge decides that having the equipment could reduce discharge delays, reduce the number of days spent in hospital, or reduce the number of calls to the patient’s GP, 111, or 999. The trial ran for six months until the end of July and will be widened to include the short-term services such as rapid response and reablement teams.

## Elective performance

Our achievements and planning during the period 2022/23 will influence local health and care landscape for many years to come. During the past year we have been under scrutiny by NHS England national and regional teams. During the year we were placed in Tier 1 monitoring for cancer and routine care, requiring the highest levels of scrutiny and oversight.

Since year end, we have delivered material improvements in our cancer and planned care pathways and have met the threshold in cancer to be downgraded from Tier 1 to Tier 2, improving on the efficiencies derived during 2022/23. At the same time, we were the only Devon acute provider to achieve the target of no one waiting more than 104 weeks to begin treatment by the end of March 2023. These achievements alongside our plans to expand our theatre and diagnostic capacities in 2023/24 are key to us delivering better health and care for all in line with our organisational vision.

~~Our people~~

Quality Goals

Our understanding of quality reflects the description of quality as set out in the '*High Quality for All, NHS Next Stage Review' (2008).* The three components of quality; safety, effectiveness and patient experience are linked. A service cannot be judged to be excellent because it is safe while ignoring its effectiveness or people's experience.

We held a number of listening and engagement sessions with our people between February and June 2021 to help us identify our key issues and explore the options to address them. Together we co-designed our four quality and safety goals for 2022/23 which are aligned to our vision for better health and care for all.

In the Quality Account for 2022/23, we share our progress against the clinical improvement priorities we agreed against the four quality goals, specifically:

- ✓ sepsis
- ✓ deteriorating patient
- ✓ falls
- ✓ nutrition and hydration
- ✓ experience of patients on discharge.

Supporting our approach to moderinising our approach to quality, our digital transformation team has worked tirelessly on the development of the outline business case for an Electronic Patient Record (EPR), which was approved by our Board of Directors in March 2023. We are one of the priority trusts set to receive funding from the National Frontline Digitisation Programme and this investment will be a critical part of the transformation of our services.

Our services across Devon remain challenged and over the last year there has been a real focus on improvement by working in partnership with local health and care providers. We have collaborative arrangements in place to improve the way we deliver our acute care and community services.

Our commitment to Building a Brighter Future for our patients, staff and local communities is outlined within our strategy and there has been a significant amount of progress made to attract investment to improve our infrastructure. Our virtual ward investment means that we can care for more patients who require specialist oversight in their own homes. Alongside this we have secured additional investment in day surgery and endoscopy facilities. Our strategic outline case for investment from the New Hospital Programme has been submitted to the national team and we are preparing our site enabling plans.

Our communications and engagement team are now working within their new structure and delivering on our commitment to meaningful conversations, which are aligned with our plan to improve our services aligned with our compassionate leadership approach. This engagement aims to ensure that our improvement ambitions are owned by all members of our team and we each feel empowered to make a difference to the people we serve.

COVID-19 and flu immunisation programme

In September 2022 we launched our joint COVID -19 and flu immunisation programme for all our people directly employed on trust contracts. More than 65% of our people took up the offer of vaccination.

Transformation and partnerships

During the year we made considerable progress in developing our capacity and capability to innovate and improve by investing in our central team and creating a culture of improvement through a comprehensive coaching programme. Our improvement and innovation team provide expertise and support for key goals and priorities within our strategy including:

- our quality goals (see below) and the delivery of our four quality pillars
- performance improvement for emergency, elective, cancer and community services
- improving our financial efficiency
- transforming services for our future.

Our people

There has been an increased focus on transforming how our workforce is rostered, utilising e-rostering, enabling us insights into hours worked and the efficient use of bank and agency workers where need arises. This has enabled us to further embrace digital transformation to analyse our workforce expenditure and management.

Monthly analysis is performed on our workforce information to ensure that we are manging absences, vacancies, and training. Whilst we have remained in normal tolerance levels throughout the year, absence due to sickness did noticeably increase during the winter months and therefore the use of agency workers to maintain safe staffing levels did increase.

The protection of staff and patients was a major concern during the COVID-19 pandemic. We have continued to follow national and local guidance in our response to the virus as well as continue to ensure availability of medically fit staff to provide care for our patients and the NHS nationally. This has been significantly challenging so there remains a continued focus on ensuring we actively support the health and wellbeing of our people including their emotional wellbeing, while ensuring we are able to move people to support clinical areas where needed.

## FURTHER PERFORMANCE ANALYSIS

COVID-19 and flu immunisation programme

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Quality Goals

Our digital transformation team have worked tirelessly on the development of the outline business case for an Electronic Patient Record (EPR), which was approved by our Board of Directors in March 2023. We are one of the priority trusts set to receive funding from the National Frontline Digitisation Programme and this investment will be a critical part of the transformation of our services. Using the EPR as our digital enabler, we will be able to work more effectively with neighbouring trusts, and primary care using the Devon Shared Care Record.

Our services across Devon remain challenged and over the last year there has been a real focus on improving services by working in partnership between all health and

~~social care organisations. Our teams have been collaborating in developing improvements in services as part of the Acute Provider Collaborative and like many parts of the country, we believe that our services are stronger and more sustainable when we work together with our partner organisations.~~

~~Our commitment to Building a Brighter Future for our patients, staff and local communities is outlined within our strategy and there has been a significant amount of progress made to attract investment to improve our infrastructure. Our virtual ward investment means that we can care for more patients who require specialist oversight in their own homes. Alongside this we have secured much needed investment in additional day-surgery and endoscopy facilities. Our strategic outline case for investment from the New Hospital Programme has been submitted to the national team and we are preparing our site enabling plans.~~

~~Our communications and engagement team are now working within their new structure and delivering on our commitment to meaningful conversations. Meaningful conversations with our people are core to our regain and renew plan, which aims to support us the deliver the transformation needed to provide better care and better value and to exit SOF4 This aligns with and is supported by our compassionate leadership approach. This engagement aims to ensure that our improvement ambitions are owned by all of us and we each feel empowered to make a difference to the people we serve.~~

~~Going concern~~

~~Our financial statements have been prepared on a going concern basis.~~

~~International Accounting Standard (IAS) 1 requires the Board to assess, as part of the account's preparation process, our organisation's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the trust without transfer of its services to another entity within the public sector.~~

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~~Further performance analysis~~

## National standards

This performance overview provides information about how we have performed against agreed operational objectives during the year.

2022/23 has been a challenging year for the Trust with ongoing recovery from the COVID-19 pandemic. Workforce and estates capacity, along with other factors,

resulted in a lower level of clinical activity than planned which impacted on elective performance and saw waiting lists climb. Across Urgent and Emergency Care performance patient flow was the main operational challenge resulting in increased length of stay and frequently full to capacity in the Emergency department and assessment units. The 4-hour standard and ambulance handover delays did not meet planned levels of performance.

The Trust, along with other providers in Devon, has experienced long patient waits for Referral to Treatment and cancer care. Since June 2022, the Trust has been required to comply with Tier 1 performance reporting, Tier 1 being the highest level of regulatory performance oversight.

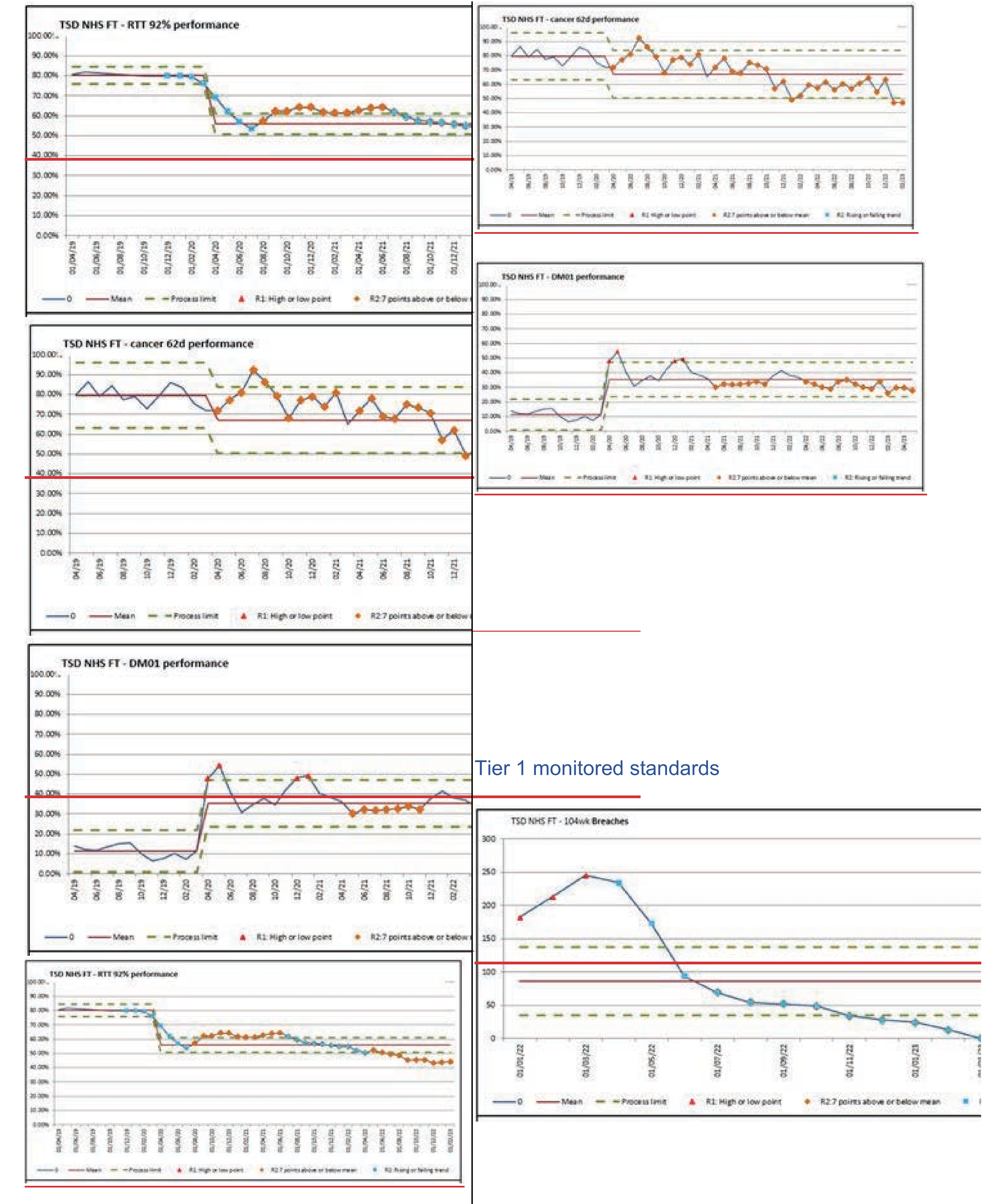
The two areas of Tier 1 performance requiring improvement are against Referral to Treatment long waits over 104 and 78 weeks, and against the number of patients waiting over 62 days for treatment following an urgent cancer referral.

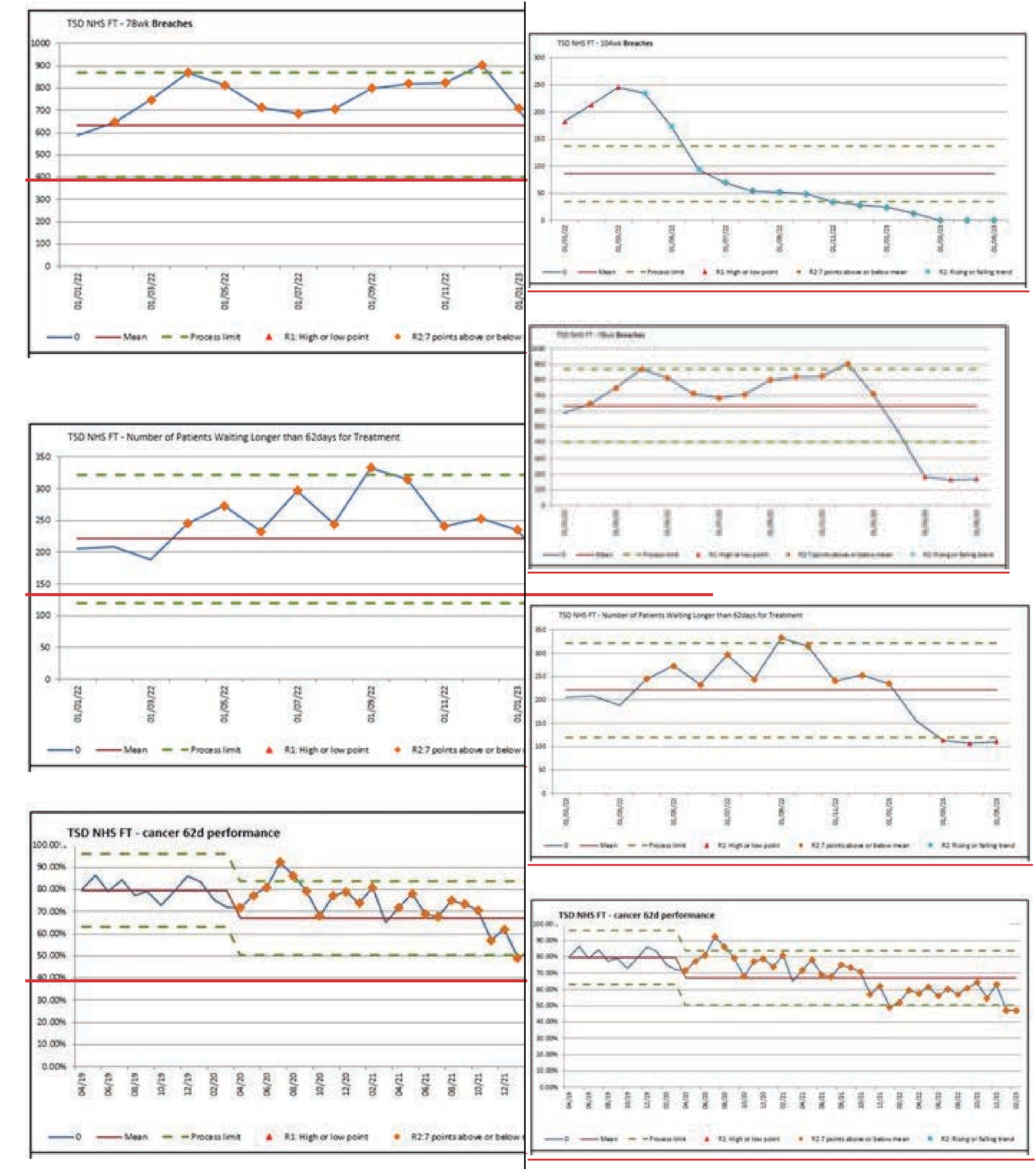
Tier 1 oversight required weekly meetings with the Trust's Chief Operating Officer and the South West Region Performance Director to review progress against plans. At the end of March 2023, the Trust had achieved the clearance of all 104-week waiting patients, delivered a total of 183 against the agreed trajectory of 176 for reduction of 78-week waiting patients, and achieved the cancer 62-day pathway backlog reduction leading to the achievement of the Tier 1 exit criteria.

During the reporting period, performance reports were provided monthly to the Finance, Performance, and Digital Committee, and to the Trust Board of Directors. These reports covered all the Tier 1 and other operational plan performance standards.

The key performance indicators for 2022/23 are shown in the analysis below, some of the introductory supporting charts shown on page x, overleaf:

NHSEI operational performance


TSD NHS FT - RTT 92% performance
TSD NHS FT - cancer 62d performance
TSD NHS FT - DM01 performance
Tier 1 monitored standards
TSD NHS FT - 104wk Breaches
0
Mean
Process limit
R1: High or low point
R2:7 points above or below mean



TSD NHS FT - 78wk Breaches
TSD NHS FT - 104wk Breaches
TSD NHS FT - Number of Patients Waiting Longer than 62days for Treatment
TSD NHS FT - cancer 62d performance
0
Mean
Process limit
R1: High or low point
R2:7 points above or below

## Four-hour Emergency Department (ED) waiting times & “No Criteria to Reside”

Performance against the 4-hour standard in the Emergency Department in 2022/23 has continued to reflect the challenges of capacity and managing daily patient flow. Long waits have continued to be experienced in the emergency department. Ambulance handover delays have also been high due to the department being full at times. Managing Covid-19 and designating ward beds to meet infection control safeguards have had a sustained on hospital capacity. Quarter 4 has seen a series of industrial actions from a Junior Doctors, Nurses and Therapists that has impacted on performance. The Trust developed a robust process to manage these to ensure patient safety.

Bed capacity has been increased by the opening of the new Acute Medical Unit (AMU) in December 2022 and the discharge lounge has been expanded.

The Trust’s improvement actions have focused on increasing the number of daily discharges earlier in the day and at weekends along with reducing the number of patients in hospital with “No Criteria To Reside” (further detail below). Progress has been seen with improved planning and daily escalation. The number of patients with no criteria to reside has reduced from a daily average of 48 (13%) in December 2022 to 28 (8%) March 2023. Ambulance handover delays have improved in Quarter 4 (Q4 month average of 789 over 30-minute delays compared to 1140 in Q3), however, remain a challenge with further improvement required in 2023/24.

- The Plan for 2023/24 is to meet the new national 76% operating plan target against the 4-hour performance by March 2024. There are a number of further developments supported by the Urgent and Emergency Care transformation programme to increase effective bed capacity for emergency admissions, patient flow, and pathways within the emergency department. These plans include the introduction of virtual ward pathways of care to facilitate earlier

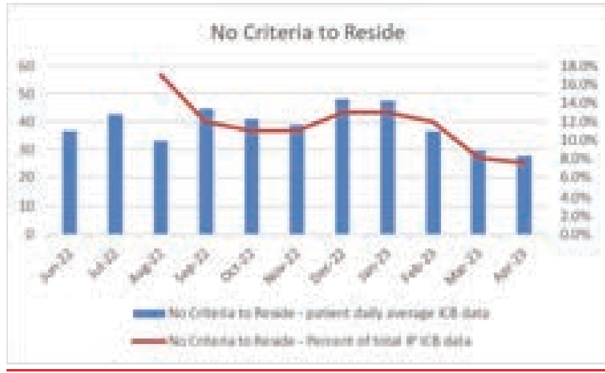
discharge and reduce admissions to improve demand for beds;

- support for the complex discharge process and the capacity of intermediate and social care to reduce further the number of ‘No Criteria To Reside’ to 5%;
- continued focus on timeliness of daily discharges, use of the discharge lounge, and increased number of weekend discharges;
- optimisation of clinical pathways to the new Acute Medical Unit to increase the number of Same Day Emergency Care discharges;
- focus on reducing breaches of the 4-hour standard for non-admitted pathways of care.
- streaming patients to alternatives to ED such as Urgent Treatment Centres, pharmacies and self-care.

Further information on "No Criteria to Reside"

As noted above, this is the status of a patient who (having undergone appropriate treatment and assessment) no longer meets the medical criteria to stay in an acute or community hospital bed; previously known as a delayed discharge.

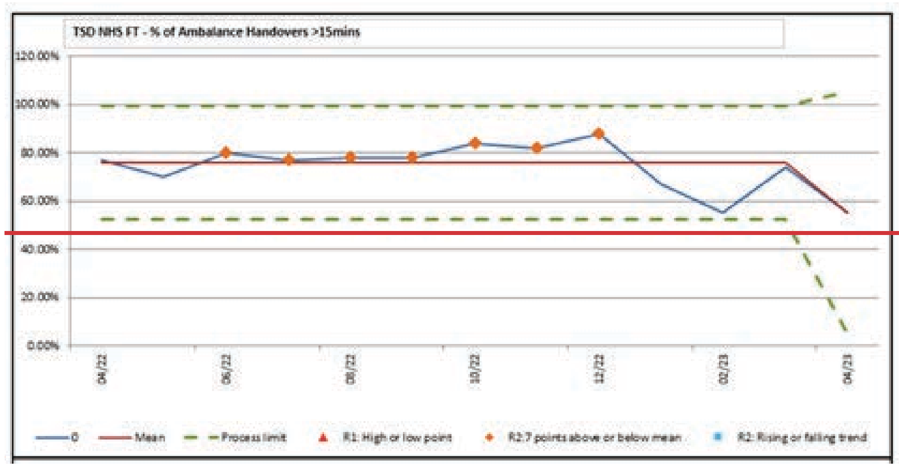
A patient occupying a hospital bed with No Criteria To Reside is potentially occupying a bed space needed for patients requiring admission from the Emergency department, Assessment units or transfer into a Community Hospital. This has contributed to delays in the Emergency department and ambulance handover delays as full capacity is reached. For these reasons the Trust has implemented an improvement programme (outlined above) supported with funding to remove any process delays in discharge and increase capacity, particularly for the more complex discharges where other care packages or intermediate care support is needed.

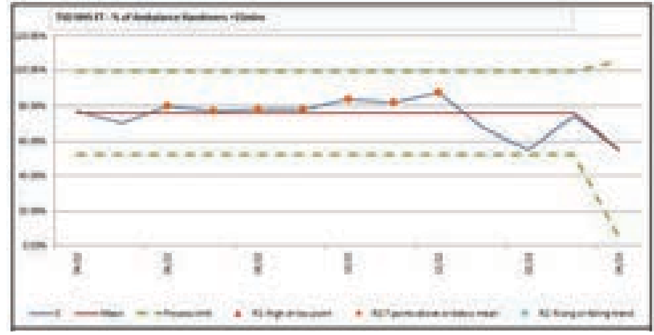



During the year the number of beds occupied in the acute and community hospitals with No Criteria To Reside has improved from over 13% of beds occupied to 8% in March and 7.5% in April 2023. The recovery target set for improvement for No Criteria To Reside is 5% for 2023/24.

Within our Urgent & Emergency Care performance analysis above, we detail how we have utilised our position as an integrated care organisation to support the associated improvement plans and supported a pilot run by the Technology Enabled Care Service (TECS), page x.

## Ambulance handovers





Ambulance Handover delays were challenging for 2022/2023 particularly in Quarters 1-3 with 70-88% of all arrivals in excess of the 15-minute handover standard. Quarter 4 saw the opening of the Acute Medical Unit and provided support to patient flow in the hospital. During the same Quarter the Trust placed a key focus on committing to improving the two main causes of patient flow imbalance by improving performance by increasing the number of patient discharges before noon and increasing the number of weekend discharges.

As a result of the above the Trust saw a benefit to flow within the hospital and emergency department and as result a positive reduction in handover delays to 55% over 15 minutes in April 2023.

The plan for 2023/34 to continue to build on the improvements above and through the Urgent and Emergency Care Board work towards no ambulance delays at the end of March 2024.

### Referral to treatment (RTT) access times

The number of patients waiting for treatment increased during the year with 40,180 patients waiting at the end of March 2023 for first definitive treatment, up from 37,261 at the start of the year. The number of patients waiting over 104 weeks, however, has been reduced to zero in this time and the Trust achieved its Tier 1 improvement trajectory to reduce the number of patients waiting over 78 weeks.

The Day Surgery Unit is a national exemplar in day case surgery completion rates and productivity. During covid escalation the Day Surgery Unit was used periodically as covid escalation for emergency admission assessment with a consequential increase of day surgery waiting lists. In April 2022, following the completion of the interim medical assessment areas the Day Surgery unit was fully restored to elective use. This has enabled teams to increase the number of day case procedures undertaken and start to reduce the number of patients waiting for day case procedures.

In 2022/23 the Trust worked closely with system partners to make use of allocated capacity at the former Nightingale Hospital in Exeter recommissioned to provide elective Orthopaedic short stay procedures and diagnostic hub. In 2023/24 this allocation of capacity has been increased with cataract procedures also now commenced.

In the outpatient setting of care, challenges have been seen with increases in waiting times for outpatient appointments and outpatient treatments. Through a focus on outpatient productivity, including pathways to utilise virtual non-face to face appointments and managing follow up pathways to release capacity, performance has started to improve. Work continues to support patient capacity and productivity through the outpatient service transformation programme and insourcing of additional clinical capacity in the most challenged areas.

The plans for 2023/24 are to have no patient waiting over 65 weeks. These plans are reliant on recruitment to vacant posts, sourcing of additional capacity and system mutual aid. The Trust has successfully bid to increase day surgery and endoscopy theatre capacity with two additional day surgery theatres and an additional endoscopy suite scheduled for completion in Quarter 4 2023/24.

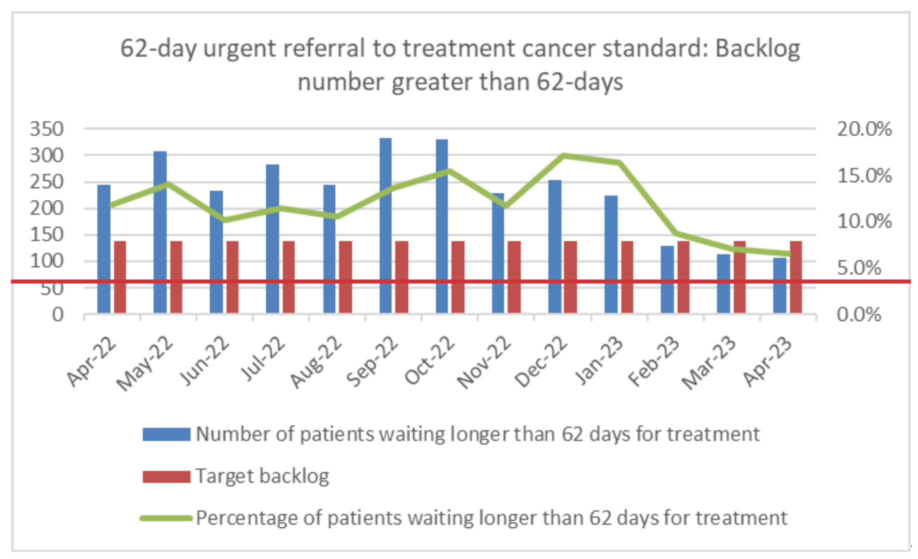
## Referral to Treatment - 65 week wait Tier 1 monitoring and trajectory

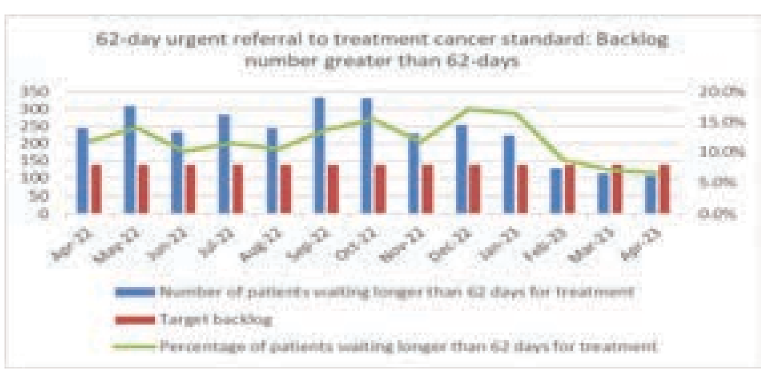
## Cancer standards

The Trust maintained its commitment to prioritise delivery of cancer treatments. The Trust, however, entered Tier 1 performance monitoring by NHSE due to the increasing number of patients waiting beyond 62 days for treatment following urgent referral. Since November 2022 there has been steady improvement with the backlog reduction meeting the threshold for stepping down out of Tier 1. This number reduced from 333 patients in November 2022 (13.6% of total list) to 114 patients (7% of total list) by end of March 2023.

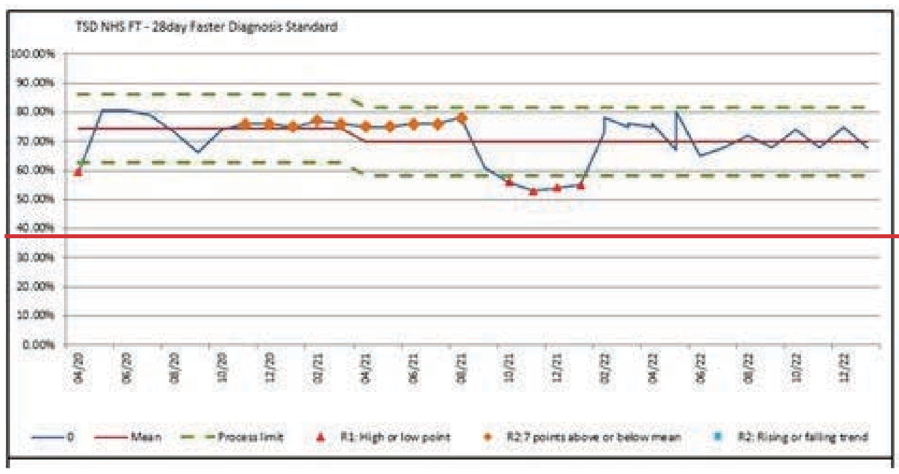
Over the year the Trust has not consistently met the 14-day urgent referral to be seen, nor 28-day from urgent referral to diagnosis standards. There are known challenges and risks. However, close monitoring is in place with action plans reviewed through cancer performance oversight. In March 2023 the Trust achieved 77.4% against the 28-day referral to diagnosis standard (target 75%) and 76% against the 2ww standard (target 93%).

### Over 62-day referral to treatment standard: greater than 62-day backlog (open pathways)




## Faster diagnosis 28-days from referral cancer standard

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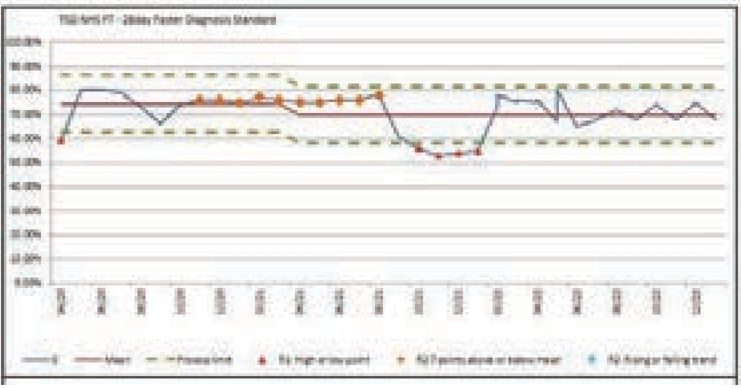


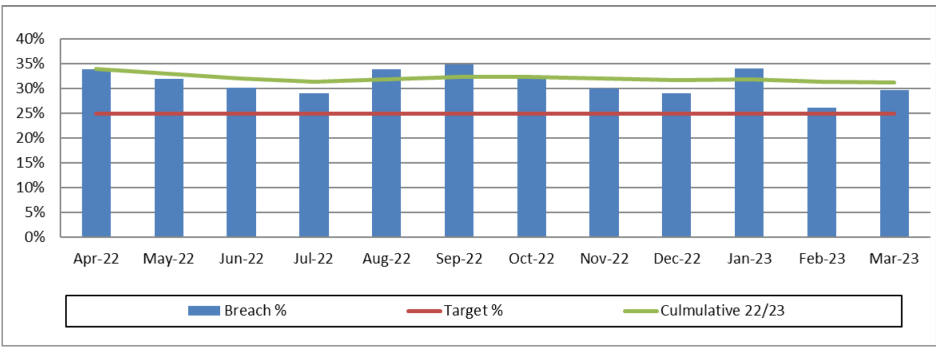
## Diagnostics

Diagnostics: Demand for diagnostic tests has continued to increase. The delivery of required levels of capacity in CT and MRI is dependent upon the sourcing of additional capacity using mobile units. The Trust will commission a new Radiotherapy Planning CT scanner at Torbay which will be operational by September 2023 and will strengthen our Clinical Oncology pathways. The Nightingale Hospital Exeter has continued to support Torbay by offering additional CT and MRI capacity.

Recruiting to staff vacancies across the major diagnostic specialties remained a challenge throughout the year.

Endoscopy services has used additionally sourced weekend capacity throughout the year to stabilise waiting lists along with additional mobile capacity to support waiting list initiatives in preparation to the estates works to create additional facilities that will impact for a period in 2024/25.

### Diagnostic greater than six-week wait breaches as a percentage of total waits




## Equality of service delivery

The Trust maintains its approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting patients by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact with patients is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should a patient's condition change or they fail to engage with offered appointments.

The Devon System is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital

Exeter as a system resource to support additional capacity for diagnostics, orthopaedic, and ophthalmology treatments.

Assurance and performance monitoring: Weekly assurance meetings are held with operational leads and the System Care Group Directors reporting to the Chief Operating Officer.

These meetings are in addition to the monthly Integrated Service Unit (ISU), executive-led, Integrated Governance Group (IGG) Meetings where performance is reviewed with system leadership teams following each ISU's monthly governance process.

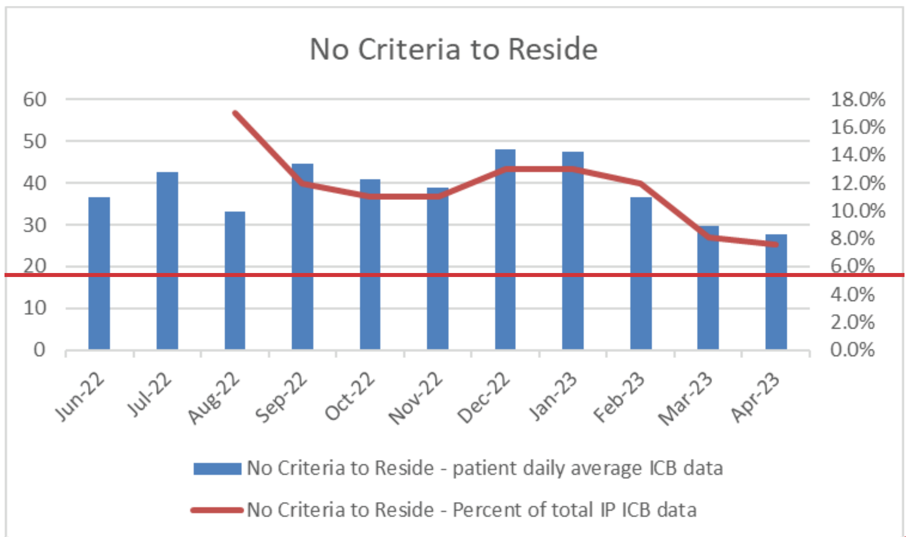
In 2023/24, monthly Urgent Care and Planned Care Board meetings are now established to track the delivery of transformation programme and performance against agreed plans.

This process gives the Executive Team and Board of Directors assurance in relation to performance monitoring, escalation of performance risks where additional support is needed, and actions being taken.

## Other areas of Performance to note

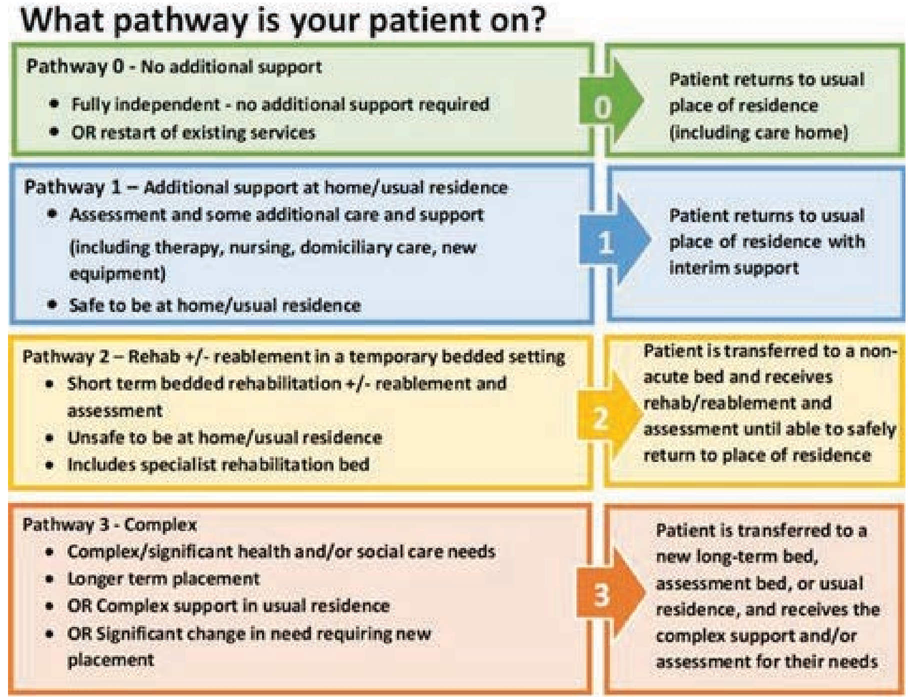
~~No Criteria to Reside~~
~~This is the status of a patient who (having undergone appropriate treatment and assessment) no longer meets a medical criteria to stay in an acute or community hospital bed. Patients who are identified as having No Criteria To Reside were previously known as a delayed discharge.~~

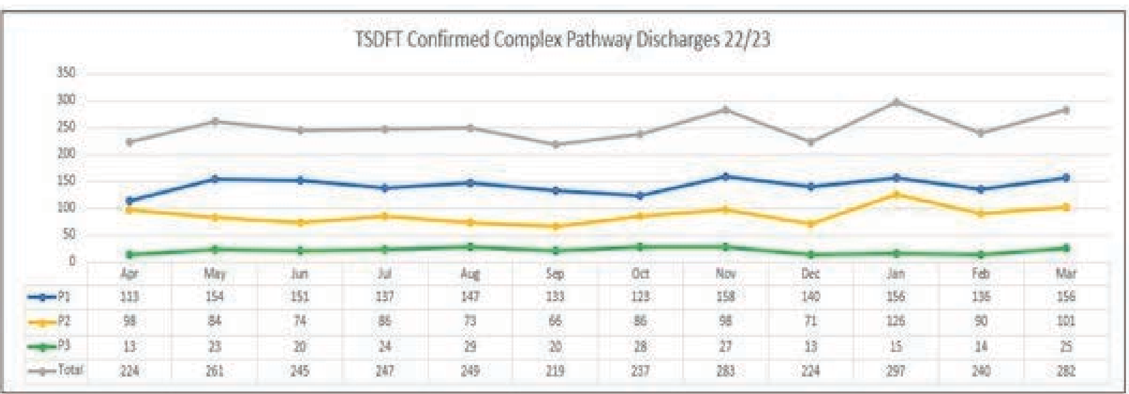
~~A patient occupying a hospital bed with No Criteria To Reside is potentially occupying a bed space needed for patients requiring admission from the Emergency department, Assessment units or transfer into a Community Hospital. This has contributed to delays in the Emergency department and ambulance handover delays as full capacity is reached. For these reasons the Trust has implemented an improvement programme supported with funding to remove any process delays in discharge and increase capacity, particularly for the more complex discharges where other care packages or intermediate care support is needed.~~




~~During the year the number of beds occupied in the acute and community hospitals with No Criteria To Reside has improved from over 13% of beds occupied to 8% in March and 7.5% in April 2023. The recovery target set for improvement for No Criteria To Reside is 5% for 2023/24.~~

## Complex Pathway Discharges




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P1 | 113 | 154 | 151 | 137 | 147 | 133 | 123 | 158 | 140 | 156 | 136 | 156 |
| P2 | 98 | 84 | 74 | 86 | 73 | 66 | 86 | 98 | 71 | 126 | 90 | 101 |
| P3 | 13 | 23 | 20 | 24 | 29 | 20 | 28 | 27 | 13 | 15 | 14 | 25 |
| Total | 224 | 261 | 245 | 247 | 249 | 219 | 237 | 283 | 224 | 297 | 240 | 282 |

The total number of patients discharged through pathways 1-3 has remained fairly consistent throughout most of the year, averaging 251 complex pathway discharges per month. Pathways 1-3 are considered ‘complex’ as patients require support to enable a safe discharge.

During December the number of pathway 2 patients discharged decreased. There was also an increase of Covid cases which led to ward closures and care homes adhering to the guidelines for admission.

Throughout early January, providers began to accept new referrals again, and additional block contracted beds were purchased to support discharge into temporary bedded placement. This resulted in a year high for Pathway 2 discharges, and a total of 297 complex pathway discharges for January.

Across the 12 months the following numbers of patients were discharged on each pathway

| Pathway | % | Actual |
|---|---|---|

| | | |
|---|---|---|
| 1 | 56.65 | **1704** |
| 2 | 35.01 | **1053** |
| 3 | 8.34 | **251** |

## Average Length of Stay

The average length of stay in 2022/23 has increased however this remains in line with other South West Provider Trusts. In 2022/23 the average length of stay for patients admitted as an emergency and staying overnight was 7.9 days and this compares to 7.6 days average across other South West provider Trusts. Infection issues, specifically Covid, have contributed to this increase length of stay. Moving into 2023/24 reducing length of stay remains an ongoing key focus for the Trust to support both elective and non-elective activity and as such has been recognised in improvement plans specifically centered on early morning discharge, discharges before 5pm and at the weekend.

## Stroke care

Patients presenting with suspected Stroke require rapid assessment diagnostics and dedicated rehabilitation care. The Sentinel Stroke National Audit Programme (SSNAP) measures the time critical processes of care provided across acute and community settings. The Trust did not meet the standards for the percentage of patients admitted to a stroke unit within 4-hours of arrival or the percentage of patients spending 90% or more of their hospital stay on a dedicated stroke ward. The Trust has a Stroke Improvement Plan to support patient outcomes and achievement of time critical standards. This plan is managed through the clinically led Stroke Governance meeting.

## Winter planning 2022/23

The Trust improved its operational resilience heading into winter with an understanding that Covid and general winter pressures would be challenging and there would be an ongoing need to clinically risk management patients and importantly support the ongoing work to improve ambulance handovers and response times.

In conjunction with Devon system wide partners the Trust focused on the following key themes of improvement:

- Establishing a Winter Control Room to support daily operational challenges
- Better support for people in the community
- Delivering on our ambitions to maximise bed capacity and support ambulance services
- Ensure timely discharge and support people to leave hospital when clinically appropriate

Key areas of support that helped maintain the resilience during the winter period were the continuation of 11 Emergency Department Escalation beds, the expansion of the discharge lounge, opening of the new Acute Medical Unit and maintaining McCullum ward for winter escalation. Community support in the form of additional Care Home placements and packages of care likewise contributed to resilience.

### Maternity Performance 2022/23:

Maternity assurance metrics are based on recommendations to meet the national priorities to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025.They are also based on the requirements set out in the Maternity Incentive Scheme (MIS) as part of the Clinical Negligence Scheme for the Trust (CNST) as well as those recommendations from both the Ockenden and East Kent Hospitals reports.

A monthly dashboard is produced which is monitored via maternity governance group. Metrics are shared via quality assurance groups within the organisation. An integrated performance report is shared at the monthly Trust Board meetings.

### Birth rate

The number of births for 22/23 was 1,847. This is a reduction from 21/22 when it was 2,073. Reduction in birth rate is a national trend.

### Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 22/23 – there were 5 deaths.

Torbay's perinatal mortality rate for 2022 is 4.2% which is the same as the national average. A deep dive/thematic review was carried out into all deaths in 2022 and no themes or issues with care were identified.

### Smoking rates

There has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically the SATOD data was 13-15%. With the introduction of the Smoke-free Pregnancy team this rate has dropped to 7.3% for the year 2022/23. This is below the national average of 8.6%.

### Identifying fetal growth restriction

Data on our detection of small for gestational age (SGA) babies in Quarter 4 of 22/23 has evidenced performance above the recommended average. Torbay is one of the Top 10 Trusts in the country for detection of small babies. The Trust has achieved a detection rate of 69.2% which is significantly higher than the National average of 43.6%.

## Financial Performance

### Funding overview

We earned over £644 million of income during 2022/23, primarily from clinical activities, but also received a significant contribution from education and training and other income generation activities.

In 2022/23 the majority of our clinical income and adult social care income was received through block contract income streams received via NHS Devon Integrated Care Board and Torbay Council respectively.

The funding arrangements for the 2023/24 financial year continue to be mostly block contract related, but reduced financial support is now in place for our response to COVID-19. Greater financial emphasis is also being placed on earned elective recovery income to reduce waiting lists on planned care pathways.

Excluding the cost of pay awards to staff, which are funded centrally, planned income is forecast to reduce by circa £5m in 2023/24. This coupled with recurrent savings shortfalls brought forward from 2022/23 totaling circa £15m, further forecast significant inflationary cost pressures on consumables and care services provided by the Independent (out of hospital) Sector, we are forecasting a deficit of £32.6m during 2023/24, after an in year 2023/24 planned savings target of £46.6m. During this period of time, interim support in the form of Public Dividend Capital (PDC) from the Department of Health and Social Care (DHSC) will be accessed to ensure that adequate financial support is in place throughout 2023/24.

### Value for Money

To help demonstrate value for money, we use benchmarking information such as the NHS productivity metrics. For procurement of non-pay related items, we have a procurement strategy which maximises value using national contracts and through collaboration with other NHS bodies in the Peninsula Purchasing and Supply Alliance.

Under the National Audit Office ('NAO') Code for 2022/23, our external auditor, Grant Thornton LLP, will issue an Auditor's Annual Report providing a commentary on the Trust's arrangements to secure Value for Money. – Outcome to be added into the Final Annual Report version.

### Capital developments during the last year

During 2022/23 we continued to invest in our facilities and equipment and carried out capital projects including recognition of in-year Right of Use Assets additions totaling £45.9 million. In addition to this sum, we received charitable donations totaling £1.7 million. Part of ~~thou~~our capital expenditure has been supported by the Public Dividend Capital received from the Department of Health and Social Care and through other sources of financing such as leases with both commercial providers and public sector organisations.

### Cashflow

Our cash position has decreased, from a starting point at 01 April 2022 of £39.3m, to a sum of £34.7m, as at 31 March 2023. The reduction in cash balance has primarily been primarily driven by movements in our working capital, most notably an increase in Inventories totaling £2.1m.

Other liabilities and Trade and other payables - creditors ~~totalling~~totaling circa £20.0m will unwind over the first part of the financial year 2023/24 as suppliers' invoices become due for payment and as deferred income performance obligations are met.

During 2023/24, we will continue to maintain detailed cashflow forecasts to assist with cash planning. We will request financial support from arrangements that are proven and already in place with the Department of Health and Social Care to ensure that we continue to meet our contractual obligations to suppliers, staff and other government agencies.

### Financial framework

Being licensed as an NHS Foundation Trust means that we are more accountable to its local public and patients. With effect from 01 April 2016, Monitor became part of NHS England / Improvement. Since that date the financial framework of NHS Foundation Trusts and NHS (non Foundation) Trusts have become more aligned.

As noted in Part II of the annual report, our financial performance continues to be monitored by NHS England~~ / Improvement.~~

### Accounting framework

As an NHS Foundation Trust, we apply accounting policies compliant with the Department of Health and Social Care's Group Accounting Manual (GAM). The DHSC GAM includes mandatory accounting guidance for DHSC group bodies completing statutory annual reports and accounts. These group bodies include clinical commissioning groups, NHS trusts, NHS foundation trusts and arm's length bodies.

The GAM is approved by the HM Treasury Financial Reporting Advisory Board.

### Accounting policies

Accounting policies for pensions and other retirement benefits are set out in a note to the full accounts (note 1.8) and details of senior employees' remuneration are given in the Remuneration Report.

## Charitable funds

Torbay and South Devon NHS Charitable Fund is a registered charity (number 1052232) and as such a separate legal entity, established to hold charitable donations given to Torbay and South Devon NHS Foundation Trust. Donations are received from individuals and organisations and are independent of the monies provided by the government.

Based upon the most up to date figures (subject to audit), in 2022/23 the Charitable Fund received donations and legacies totalling £2,339,000.

Included within this figure were extremely generous donations from the Torbay Hospital League of Friends (£1,570k, including funding for equipment for the new Acute Medical Unit and CT scanners) and Brixham Hospital League of Friends (£309k). The Charitable Fund also received £163,000 from Torbay Medical Research Fund in respect of various research projects.

We continue to complete projects funded by grants from NHS Charities Together, the organisation which distributed donations given to the NHS in response to the COVID-19 pandemic.

Other donations have been used to purchase numerous items of medical and other equipment, as well as supporting the training and development of staff and patient/client welfare. Full details can be found in our Charitable Fund Annual Report and Accounts, which we produce in our role as corporate trustee.

## Emergency Preparedness, Resilience and Response (EPRR)

### NHS England EPRR Assurance

On 30 November 2022, our Board of Directors received and approved the outcome of the NHS England / Integrated Care Board EPRR core standards assessment for 2021 in relation to our responsibilities as a category 1 responder under the Civil Contingencies Act (2004). Assurance was provided to our Board that against the 64 standards we scored: 60 fully compliant standards and four partially compliant standards moving us to an overall rating of substantially compliant from partially compliant following the previous year, demonstrating a significant improvement.

During the year we implemented our incident response plan and began rolling out a training programme across the organisation to staff who are involved in such situations.

In addition to the core standards assessment, we participated in an external audit from South Western Ambulance Service NHS Foundation Trust in relation to the Chemical, Biological, Radiological and Nuclear (CBRN) capability audit. We successfully passed the audit with no further recommendations, evidencing the process in place to manage a CBRN incident.

### EPRR Incidents 2022/23:

During the year, we recorded six business continuity incidents through our Datix system. We had no confirmed major incidents. We are unable to report on critical incidents as the reporting mechanism was partway through the financial year.

The business continuity incidents related to:

- a failure of water pump, preventing a loss of facilities
- a cyber-attack occurred on a contractor that supplies our catering supplies
- red warning for extreme heat
- water leak in a patient facing area
- power outage in theatres and the main entrance corridors.

'Hot' debriefs were completed and lesson have been identified and added to our lessons identified tracker.

### EPRR risk register

The EPRR risk register is being reviewed to assist in mitigating organisational and community risk. This review of the risk register then will aid the work plan for the EPRR team for 2023/24.

### EPRR training and exercising

During the year the EPRR team delivered the following training courses:

| Course name | Number of roles completed course | Number of roles required to complete the course (KPI) | Rating In performance |
|---|---|---|---|
| Loggist training | 17 | 32 | Less than 75% |
| Tactical command | 34 | 62 | Less than 75% |
| Strategic command | 4 | 14 | Less than 50% |
| Decontamination recertification | 9 | 32 | Less than 50% |
| Total | 58 | 140 | Less than 50% |

As a result of OPEL 4, industrial action and critical incidents, significant training was cancelled over the course of the year. The priority for 2023/24 will be to deliver more than 75% training to people in key roles across the organisation.

During the year we took part in two main exercises. 'Exercise Drogon' on 01 September 2022 tested NHS Devon's system critical incident plan. On 09 March 2023 we were involved in a test of the mass casualty distribution plan with South Western Ambulance Service NHS Foundation Trust. The debrief reports will be shared for lessons to be learnt and adopted.

### Environmental matters and the impact on the environment

We recognise that climate change and carbon emissions present a risk to health at both the national and global level. As a provider of healthcare and as a publicly-funded organisation, we are committed to ensuring the long-term sustainability of the natural environment and a contribution to the reduction of carbon emissions, in order to deliver sustainable healthcare and to safeguard human health.

- In 2020, NHS England defined two clear targets, which we are aligned to:for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (the NHS Carbon Footprint Plus)), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Our green plan was formally approved at our Board of Directors meeting in February 2022 and forms part of our broader Integrated Care System green plan for Devon and is also a key enabling plan for our ~~organizational~~organisational strategy and vision of better health and care for all.

Our green plan defines our commitment to environmental sustainability with a primary focus on how we will drive towards the NHS net zero targets. The key outcomes include:

- ensuring we are aligned to the NHS-wide ambition, and that of the Integrated Care System for Devon to become the world's first healthcare system to reach net zero carbon emission
- prioritising interventions which improve the quality of healthcare we deliver, while also tackling greenhouse gas emissions and broader sustainability challenges
- defining our strategic approach in such a way that we make the right sustainability decisions first time.

A further update on progress against our green plan was presented to our Board of Directors in February 2023 and confirmed that good progress has been made against the majority of the actions and commitments we have made, along with our commitment to decarbonisation, sustainable development and achievement of national objectives, continue to be key priorities for us.

Through our green plan, we are focusing on the following areas to achieve net zero carbon:

- how we manage our existing buildings in the context of energy use and decarbonisation
- how we build new buildings that are net zero carbon in their construction and operation
- how we manage our consumption of water
- how we manage our waste streams
- how we support and develop sustainable travel and transport for patients, staff and visitors, encouraging sustainable travel modes where appropriate
- how we manage the reduction of our carbon footprint relating to anaesthetic gases and other pharmaceutical products
- how we innovate to provide net zero carbon healthcare embracing new working practices and digital enablers
- how we work with our supply chain to reduce, minimise and eventually decarbonise
- how we encourage and develop biodiversity across our green spaces for the benefit of patients, staff and visitors
- how we adapt to ensure we meet the challenges that will arise from climate change.

Our achievements this year include:

- the implementation and review of our green travel plan, which was underpinned by several initiatives, including a phased implementation of virtual ward models for frailty and respiratory services, and the launch of a full review into the management of staff parking, with a view to improving uptake in more environmentally-friendly transport and travel methods
- the roll out of carbon-literacy training to our key stakeholders and decision-makers
- the cost-neutral creation of a new Energy and Decarbonisation Manager post within our Workplace Team, focused on optimisation of our approach to utilities consumption
- the continued roll out of habitat-preservation and bio-diversity initiatives across our sites, particularly at Torbay Hospital, including wild seed meadows, bug hotels, sensory walks, and bat and bird boxes
- conclusion of our heat decarbonisation plan referenced in the previous year's annual report, which is being owned by the Technical Centre of Excellence within the Workplace Team who plan to begin implementation in 2023/24
- developed and agreed a specification for a power purchasing agreement, delivering locally sourced renewable energy directly to our Torbay Hospital site in order to reduce reliance on more traditional energy sources. This opportunity will form part of an open-market, competitive tender process and awarded in the latter part of the 2023/24 strategic year.

- We ensure all our capital build projects embrace our transition to carbon net zero through the design and delivery of new infrastructure and equipment. This includes removing the need for gas and using solar and air heat source pump technologies in new builds.

While our green plan focuses on 2022-2025, we will ensure it is updated and expanded regularly, as and when there is a better understanding of our environmental impacts and how to reduce them.

### Social and community issues

We are clear about our leadership role in our local health and care system. As an anchor institution we are deeply connected to our local area and we use our influence, skills and resources to benefit the communities we serve.

We recognise we have a particular responsibility to help our children and young people start well in life, giving them a good foundation of health and wellbeing that will protect them against later ill-health, while also supporting their education, training and future job prospects.

We are working with our community partners to reduce the inequalities experienced by local people. We recognise the impact on employment on long term health outcomes and are committed to providing meaningful, flexible employment for local people as well as work experience and volunteering opportunities. Through the Torbay Advice Network supported pathway local people in receipt of adult social care receive additional support to obtain and maintain employment through advice and guidance with reasonable adjustments and an access to work scheme.

We have developed several new initiatives to support employment within our local community. This includes an alliance with our local further education provider, South Devon College, to develop pathways into health and care careers. During the year we launched our new health car support worker scheme to support people into much needed roles and began working in partnership with the job centre on the volunteer to career programme which supports people through volunteering into secure employment. We also joined the 16-18 year old’s T levels scheme and expanded our placement opportunities with the first cohort of industrial placements offered this year.

We have also committed to sharing our apprenticeship levy programmes to give smaller employers in Torbay and South Devon opportunities to harness apprenticeship opportunities and we are developing a new work experience online platform to give everyone the opportunity to see what our local career opportunities. We are also working with private, voluntary and independent sector partner across Torbay and South Devon to broaden our reciprocal placements offer to help improve career prospects across the whole health and care sector.

We also recognise the impact of housing, education, environment, debt and many other factors on people's health and wellbeing and will continue to work closely with our communities and in partnership with others to do our bit in making life better for all. We are proud signatories of the Torbay community wealth building memorandum of understanding and we are working together with our partners to improve how we support the local economy from the goods that we buy, to the people that we employ, the assets that we own and the powers that we have to bring about positive change that will benefit local people.

In addition, our staff support many health-related groups in both a business and voluntary capacity. We support and enable our staff to play a full part in the community, for example by acting as governors for schools and colleges.

### Anti-bribery and human rights issues

Our internal processes ensure consistency with our zero-tolerance approach to bribery and we work closely with our Local Counter Fraud Specialist (LCFS) to raise awareness of our policies and procedures through local induction sessions and bespoke training. We have continued to use the management database system to support our compliance with NHSE guidance on managing conflicts of interest. have continued to run awareness campaigns to remind staff of the requirement to comply with NHSE guidance and the Bribery Act 2010.

We encourage anyone with a concern to speak out and report concerns through our governance processes and our policies and procedures.

Our people can raise concerns through internal channels, either via the Freedom to Speak Up Guardians (FTSU) or the LCFS. The FTSU and LCFS report regularly to the Board and the Audit Committee, respectively and the FTSU line management is direct to the Chief Executive. The FTSU Guardian has a standing invitation to the Board Sub-Committee with responsibility for workforce, staffing and wellbeing – the People Committee - and is a regular attendee.

As an organisation we recognise the benefits of ethical procurement and professional training. We endorse membership of the Chartered Institute of Procurement and Supply for our professional buying team. This includes the adoption of the Institute’s code of conduct, which is also included within our Standing Orders and Standards of Business Conduct. We encourage best practice within our supply chain by ensuring we are compliant with legislation. We also encourage our suppliers and contractors working on our behalf to challenge unethical behaviour and promote a ‘speak up’ culture.

The Trust has a Counter Fraud, Bribery and Corruption policy which deals with the specific issues in the title. The Trust’s policies relating to Conflicts of Interest, Gifts and Hospitality, and its Disciplinary policy link to Counter Fraud. Additionally, appropriate policies are reviewed throughout the year for Fraud resilience and, where applicable, are updated to protect the Trust from economic crime and wrongdoing. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients and staff.

We have a Board approved anti-slavery and human trafficking statement, which is published on our website. We are playing a leading role in the development of a Devon and Torbay modern slavery adult victims referral pathway protocol and the formulation of the memorandum of understanding between statutory agencies within the anti-slavery partnership.

## Important events since the end of the financial year

There are no important events since the end of the financial year to report.

Liz Davenport
Chief Executive
28 June 2023

# PART II – ACCOUNTABILITY REPORT

## ~~DIRECTORS' REPORT~~

## Directors' Report

The directors are responsible for the preparation of the financial statements in accordance with Department of Health and Social Care Group Accounting Manual and that the account gives a true and fair view. The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance, business model and strategy.

### The Foundation Trust Board of Directors

Our Board of Directors ('the Board') has collective responsibility for the exercise of all our powers. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for the members of the organisation and for the public. Directors are jointly and severally responsible for all the decisions of the Board.

The Board of an NHS Foundation Trust is accountable for the stewardship of the organisation, our services, resources, staff, and assets. The arrangements established by a Board must be compliant with the legal and regulatory framework, protect and serve the interests of stakeholders, specify standards of quality and performance, support the achievement of organisational objectives, monitor performance, and ensure an appropriate system of risk management and internal control.

Our constitution specifies that the Board of Directors shall comprise ~~:~~a non-executive Chairman; other non-executive directors; and executive directors.

- To ensure the balance and effectiveness of the Board, our constitution further requires that: one of the Executive Directors shall be the Chief Executive
- the Chief Executive shall be the Accounting Officer
- one of the Executive Directors shall be the Chief Finance Officer
- one of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
- one of the Executive Directors shall be a registered nurse or a registered midwife
- the non-executive directors and Chairman together shall be greater than the total number of executive directors.
- the validity of any act of the organisation is not affected by any vacancy among the directors or by any defect in the appointment of any director.

Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted.

The Board is accountable to stakeholders for discharging its general duties and is responsible for organising and directing the affairs of our organisation and our services in a manner that will promote success and is consistent with good corporate governance practice, and, for ensuring that in carrying out our duties, we meet our legal and regulatory requirements. In doing so, the Board of Directors ensures that our organisation maintains compliance with its terms of authorisation and other statutory obligations.

The Board reserves some responsibilities to itself, delegating others to the Chief Executive and other Executive Directors or Committees of Directors. Those matters reserved to the Board are set out as a formal schedule which includes approval of:

- our long-term objectives and financial strategy
- annual operating and capital budgets
- changes to our senior management structure
- the Board's overall 'risk appetite'
- our financial results and any significant changes to accounting practices or policies
- changes to our capital and estate structure
- conducting an annual review of the effectiveness of internal control arrangements
- setting the corporate governance structure of its Board and Committees
- ensuring the Well-Led framework is central to the Board's oversight and assurance, utilising it within the Board's annual effectiveness review.

Our Board of Directors delegates responsibility to the Chief Executive to:

- enact the strategic direction of the Board of Directors
- manage risk
- achieve organisational compliance with the legal and regulatory framework
- achieve organisational objectives
- achieve specified standards of quality and performance
- operate within, generate, and capture evidence of the system of internal control.

## Board of Directors – disqualification

The following may not become or continue as a member of our Board of Directors:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged
- a person who has made a composition or arrangement with, or granted a Foundation Trust deed for his creditors and who has not been discharged in respect of it
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him
- a person who falls within the further grounds for disqualification as described in our constitution
- a person excluded from eligibility in accordance with the NHS Standard Form Licence Conditions, as issued from time to time.

## Composition of the Board of Directors

Our Board of Directors as at 31 March 2023 is shown below:

| Non-Executive Directors | Executive Directors |
|---|---|
| Richard Ibbotson – Chairman<br>Richard Crompton – Non-Executive Director and Vice Chair<br>Chris Balch – Non-Executive Director and Senior Independent Director<br>Jacqui Lyttle – Non-Executive Director<br>Vikki Matthews – Non-Executive Director Paul Richards – Non-Executive Director Robin Sutton – Non-Executive Director<br>Siân Walker-McAllister – Non-Executive Director | Liz Davenport – ChiefExecutive<br>David Stacey – Deputy Chief Executive and Chief Finance Officer<br>Ian Currie – Medical Director<br>Adel Jones – Director of Transformation and Partnerships<br>Deborah Kelly – Chief Nurse<br>Jon Scott – Chief Operating Officer<br>Michelle Westwood – Chief People Officer |

Note: Our Board has two non-voting Executive directors Dr Joanne Watson, Health and Care Strategy Director and Mrs Emily Long, Director of Corporate Governance and Trust Secretary. In addition, there is one non-voting associate non-executive director, Dr Peter Aitken.

Since the year-end there have been no changes in Board membership. The gender balance of the Board as at 31 March 2023 was:

| | Female | Male |
|---|---|---|
| **Non-Executive Directors** | 3 | 5 |
| **Executive Directors** | 4 | 3 |

Biographies of the members of the Board are provided in Appendix A.

## Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests which may conflict with their role and management responsibilities at our organisation. At each meeting of the Board of Directors, a standing agenda item also requires all Executive Directors and Non- Executive Directors to make known any interest in relation to the agenda and any changes to their declared interests. There are no interests which may conflict with their management responsibilities as per the requirements of the NHS Foundation Trust Code of Governance. The Chairman has no other significant commitments that affect his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

The Chief Executive's Office maintains a register of interests, and is available on our website or by contacting the Trust Secretary at the address given in Appendix B – Further information and contact details.

No political donations were made or received by the organisation in the reporting period.

## Independence of the Non-Executive Directors

Our Board of Directors has assessed the independence of the Non-Executive Directors and considers all current Non-Executive Directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement as evidenced through their declarations of interest, previous employment, or tenure.

## Committees of the Board of Directors

The Board has established the 'statutory' Committees required by the NHS Act 2006 and our constitution. The Non-Executive Nominations and Remuneration Committee and the Audit and Risk Committee each discharge the duties set out in our constitution and their terms of reference.

The Board has chosen to deploy additional 'designated' Committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and financial risk management. These are the Quality Assurance Committee, the Finance, Performance, Digital Committee, the People Committee and the Building a Brighter Future Committee.

The role, functions and summary activities of the Board's Committees are described below:

### Non-Executive Nominations and Remuneration Committee

The purpose of the Non-Executive Nominations and Remuneration Committee is to conduct the formal appointment to, and removal from office, of Executive Directors, other than the Chief Executive who shall be appointed or removed by the Non- Executive Directors subject to approval by the Council of Governors. The Committee also considers succession planning for Executive Directors, considering the challenges and opportunities facing the organisation, and the skills and expertise that will be needed on the Board of Directors in the future.

We are also required to appoint a Remuneration Committee in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the Constitution, and the NHS Foundation Trust Code of Governance.

The Non-Executive Nominations and Remuneration Committee fulfils the dual purpose of the two statutory Committees for nomination and remuneration of Executive Directors. It also decides the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and reviews the suitability of structures of remuneration for other senior managers.

The Committee met on 15 occasions in the reporting period for the purpose of considering changes in remuneration for Executive Directors and other senior managers, receiving reports on the appraisals and objective setting for Executive Directors, Executive succession planning, and to lead on the appointments of Executive Directors, namely the Chief People Officer and Chief Operating Officer. The Committee was supported in the recruitment process by an external recruitment consultant. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any matters requiring disclosure to the Board.

### Audit and Risk Committee

The Audit and Risk Committee works in parallel with the Board's Sub-Committees.

The terms of reference for the Audit and Risk Committee are published on the Trust's website. The Audit and Risk Committee reviews the effectiveness of systems of governance, risk management and internal control across the whole of the organisation's activities. In comparison, the Quality Assurance Committee reviews the actions being taken by the organisation to ensure the ongoing maintenance of standards of quality of care and improvements, where necessary, to patient experience.

- During the year the Audit and Risk Committee reviewed the adequacy of:all risk and control-related disclosure statements, together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- underlying assurance processes that indicated the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority
- the Committee's terms of reference and work plan.

The Committee sought reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness; notably, the Committee-initiated improvements to the Board assurance framework.

As part of the year-end reporting process, the Chief Finance Officer presented a summary of the financial results, an overview of the financial statements and the key areas of judgment and estimation, building on the external audit risk assessment.

The committee also received an update on the implementation of IFRS 16.

The Committee met on five occasions in the reporting period and was attended by the Chief Finance Officer and other senior managers, including the Director of Operational Finance, Chief Nurse and Interim Director of Corporate Governance. A governor observer was also in attendance. Representatives from the external auditor (Grant Thornton), internal auditor (ASW Assurance) and our local counter fraud specialist attended each meeting. The Committee undertook a self-assessment during the year and also reviewed its terms of reference. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

The external auditor (Grant Thornton LLP) has not provided any additional non-audit services during the period.

### Audit and Risk Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accounting Officer for the Foundation Trust, the Audit and Risk Committee has examined the adequacy of systems of governance, risk management and internal control within the organisation, from information supplied, and formed the opinion that:

- there is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk
- assurances received are sufficiently accurate, reliable, and comprehensive to meet the Accounting Officer's needs and to provide reasonable assurance
- governance, risk management and internal control arrangements within the organisation include aspects of excellence as well as aspects in which ongoing attention to the control improvement is required
- financial controls are sufficient to provide reasonable assurance against material misstatement or loss
- the quality of both internal audit and external audit over the past year has met all the organisation's requirements.

The Committee discharged its role through the year as follows:

- we reviewed the establishment and maintenance of an effective system of governance, risk management and intern al control across the whole of the organisation's activities (both clinical and non-clinical)
- we ensured that there was an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee. The Committee reviewed and approved the internal audit plan, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. The audit plan was reviewed during the year to ensure it remained risk based
- we considered the major findings of internal audit's work (and management's response). The internal auditor had unrestricted access to the Chair of the Committee for confidential discussion

- we reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The key audit matters related to: ISA 240 revenue risk, valuation of land and buildings, management over-ride of controls, completeness of expenditure risk and, financial sustainability in respect of the organisation's arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the Annual Report and financial statements before submission to the Board
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made we reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the organisation.

### Quality Assurance Committee

The Board of Directors has established the Quality Assurance Committee to support the Board in discharging its responsibilities for monitoring the quality of the organisation's services. This includes the essential standards of quality (as determined by Care Quality Commission's registration requirements), and national targets and indicators (as determined by NHSE's Oversight Framework). The Committee's work plan is aligned to the organisation's corporate objectives and associated risks.

The Committee reviews the outcomes associated with clinical services and patient experience and, the suitability and implementation of risk mitigation plans regarding their potential impact on patient outcomes. The Committee is also required, as directed by the Board from time to time, to consider issues relating to quality where the Board requires this additional level of scrutiny.

During the year, the Committee considered:

- the Board assurance framework and corporate level risks
- data and quality and safety metrics in relation to never events, long stay patients with mental health and domiciliary care, Venous thromboembolism (VTE), stroke, maternity and serious incidents
- quality and safety risks in relation to operational matters and harm reviews
- clinical governance framework and associated priorities
- patient safety strategy
- progress against the Care Quality Commission improvement plan
- internal audit reports relating to patient safety and quality
- patient surveys that also included reports on patient experience
- the integrated quality, finance, and performance report from a quality and safety perspective
- the Quality Account and its priorities.

A programme of service reviews during the year was introduced during the year enabling the Committee to undertake a detailed deep-dive into specific services or specialties. To date the Committee has conducted deep-dives into the following:

- Torbay Drug and Alcohol Service
- stroke services (two deep dives in the reporting year)
- support for patients with complex mental health needs
- maternity and obstetrics.

The Committee met seven times during this reporting period. Along with Committee members, the Committee was attended by a number of senior managers, including System Directors of Nursing and Professional Practice, Clinical Service Leads and the Interim Director of Corporate Governance. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was also present at the majority of meetings. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

### Finance, Performance, and Digital Committee

The Finance, Performance and Digital Committee has delegated authority from the Board of Directors, subject to any limitations imposed by the schedule of matters reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- control and management of the finances of the organisation
- target level of efficiency savings and actions to ensure these are achieved
- budget setting principles
- year-end forecasting
- commissioning
- capital planning and delivery.

The Finance, Performance and Digital Committee met on 13 occasions during this reporting period. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend each meeting and was present at the majority of meetings. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

### People Committee

The purpose of the People Committee is to provide assurance to the Board on the following:

- national workforce guidance and strategies
- the people plan and associated activity/implementation plan(s) to support our forward strategy
- key people and workforce performance metrics and targets
- provide assurance on those elements of the Board assurance framework identified as the responsibility of the Committee
- availability and opportunity for freedom to speak up and employee voice, and plans to improve staff experience in line with national staff survey findings.
- strategic people and workforce issues at national and local level
- act as an early point of contact for the FTSU Guardian to raise concerns prior to reporting to Board.

During the year, the Committee has considered:

- review of the Board assurance framework and corporate risk register, with appropriate challenge to the proposed controls and risk scoring
- deep-dives in to the achievement reviews, just and learning culture, attraction and retention of talents
- received reports on progress against our people promise and plan
- received assurance reports around education and workforce development
- reviewed the workforce information including pay and absence information
- reviewed talent management and succession planning arrangements
- received reports on the Workforce Transformation Programmes
- triangulated information to reconcile headcount and finance data.

The People Committee meets on a bi-monthly basis and is chaired by a Non- Executive Director. The Committee membership also includes two further Non- Executive Directors, Chief People Officer, Chief Operating Officer, the Chief Nurse and the Medical Director. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

### Building a Brighter Future Committee

The Building a Brighter Future Committee was established for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme 'Building a Brighter Future' and to support the successful achievement of the programme investment objectives and realisation of the stated benefits. The Committee also provides assurance around the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirms that projects are delivering the stated benefits, are value for money, and are ultimately affordable.

The Building a Brighter Future Committee meets on a monthly basis and is chaired by a Non-Executive Director. The Committee also comprises two further Non- Executive Directors, Medical Director, Chief Finance Officer and the Senior Responsible Officer/ Programme Sponsor. The Chief Executive and Audit and Risk Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

### Enhanced quality governance reporting

The Board was satisfied during the year that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information), the organisation had, and will keep in place, effective leadership arrangements for monitoring and continually improving the quality of health and social care, including:

- ensuring required standards are achieved (internal and external)
- investigating and acting on substandard performance
- planning and managing continuous improvement
- identifying, sharing, and ensuring delivery of best-practice
- identifying and managing risks to quality of care.

This encompasses an assurance that due consideration was given to the quality implications of plans (including service redesigns, service developments and cost improvement plans), in the form of quality and equality impact assessments, and that processes are in place to monitor their ongoing impact on quality and take subsequent action, as necessary, to ensure quality is maintained.

The basis of the Board of Directors confirmation was set out in the draft corporate governance statement to be submitted to NHSE. The Annual Governance Statement provides further information.

## Membership and attendance at Board and Committee meetings

The Board of Directors discharged its duties during 2022/23 in ten meetings, and through the work of its Committees. The Chairman of the Board submitted a report to the Council of Governors (CoG) at each meeting, highlighting any matters requiring disclosure to the Council.

The table ~~below~~overleaf shows the membership and attendance of voting board members who attend meetings of the Board and Board Committees during the year.

| 2022-23 | Board of Directors | Council of Governors | Non-Executive Director Nominations and Remuneration Committee | Audit Committee | Quality Assurance Committee | Finance, Performance, and Digital Committee | People Committee | Building a Brighter Future Committee |
|---|---|---|---|---|---|---|---|---|
| Number of meetings | 10 | 4 | 14 | 5 | 7 | 13 | 6 | 9 |
| Richard Ibbotson | C10(10) | C4(4) | C14(14) | - | - | - | - | - |
| Chris Balch | 10(10) | 4(4) | - | 5(5) | - | 13(13) | 6(6) | C9(9) |
| Richard Crompton* | 4(6) | 3(3) | 1(3) | 1(1) | - | C3(3) | - | 3(6) |
| Jacqui Lyttle | 4(10) | 2(4) | 7(14) | 4(5) | C5(7) | - | - | - |
| Vikki Matthews | 7(10) | 3(4) | 8(14) | 4(5) | 4(7) | - | 6(6C | - |
| Paul Richards | 10(10) | 4(4) | - | 4(4) | - | C10(10) | - | 8(9) |
| Robin Sutton | 10(10) | 4(4) | - | C1(1) | - | 13(13) | - | - |
| Sally Taylor** | 6(7) | 2(3) | 10(11) | C4(4) | - | - | - | - |
| Siân Walker-McAllister | 5(6) | 2(2) | - | - | 4(4) | - | 3(3) | - |
| Liz Davenport | 10(10) | 3(4) | - | - | - | - | - | - |
| Ian Currie | 10(10) | 3(4) | - | - | 7(7) | 11(13) | 6(6) | 6(9) |
| Judy Falcão# | 4(4) | 0(1) | - | - | 1(1) | - | 2(3) | - |
| Sheridan Flavin## | 2(2) | 2(2) | - | - | 1(3) | - | 2(2) | - |
| John Harrison ^ | 5(5) | 1(4) | - | - | 1(4) | 4(7) | 0(3) | - |
| Adel Jones | 9(10) | 2(4) | - | - | - | 12(13) | - | 7(9) |
| Deborah Kelly | 9(10) | 3(4) | - | 3(5) | 6(7) | 8(13) | 5(6) | - |
| Jon Scott^^ | 4(5) | 2(2) | - | - | 2(3) | 5(6) | 1(2) | - |
| David Stacey | 10(10) | 3(4) | - | 5(5) | - | 13(13) | - | 7(9) |
| Michelle Westwood~ | 4(4) | 1(4) | - | - | 3(3) | - | 2(2) | - |
| * Richard Crompton – commenced 01.08.22 | | | | | | | | |
| **Sally Taylor – left 31.12.22 | | | | | | | | |
| ***Siân Walker-McAllister – commenced 01.09.22 | | | | | | | | |
| #Judy Falcão – left 11.07.22 | | | | | | | | |
| ##Sheridan Flavin – commenced 12.07.22, left 26.11.22 | | | | | | | | |
| ^John Harrison – left his role as Chief Operating Officer on 17.10.22 | | | | | | | | |
| ^^Jon Scott – commenced 18.10.22 | | | | | | | | |
| ~Michelle Westwood – commenced 27.11.22 | | | | | | | | |

Figures in brackets indicate the number of meetings the individual could be expected to attend by their membership of the Board or Committee. A dash indicates that the individual was not a member. 'C' denotes the Chair of the Board or Committee.

## Performance of the Board and Board Committees

Members of the Board are subject to on-going and regular performance appraisal. The Chief Executive appraises individual Executive Directors. Non-Executive Directors and the Chief Executive are appraised by the Chairman. The Chairman was appraised by the Senior Independent Director for 2022/23 in accordance with the guidance issued by NHSE 'Framework for conducting annual appraisals of NHS provider chairs'.

The outcome of these appraisal processes was presented to the governors' Nominations and Appointments Committee and confirmed with the Council of Governors. Confirmation of the process undertaken in respect of the Chairman's appraisal has been submitted to the NHSE in accordance with the aforementioned guidance.

The Board of Directors undertakes a regular self-assessment of its performance to establish whether it has adequately and effectively discharged its role, functions, and duties.

For the reporting period, the Board's performance, considering the role, function, and work of the Board Committees, was of the requisite standard. The Board believes that it is balanced and complete in its composition and appropriate to the requirements of the organisation. This was attributed to the comprehensive annual cycle of reporting, a robust Board assurance framework and risk register, and a development plan undertaken under the guidance of the Chair and Trust Secretary.

The findings of the internal audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusion.

Similar assessment exercises were undertaken for each of the Committees of the Board, all of which were considered to have fully discharged the duties set out in their terms of reference.

## The Council of Governors

The Council of Governors is responsible for discharging the general duties set out in legislation which are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the organisation as a whole and the interests of the public.

The Council of Governors discharged its statutory duties as set in the NHS Code of Governance supported through its sub-committees and working groups.

It remains the responsibility of the Board of Directors to design and implement the organisational strategy. The Council of Governors and the Board of Directors communicate principally through the Chairman who is the formal conduit and Chairman of the two bodies. This relationship is formally extended and augmented by governors and directors' participation in Board to Council meetings to ensure constant and clear communication and co-operation between the Board and the Council of Governors. Additionally, directors regularly attend meetings of the Council of Governors. During the reporting year, hybrid meetings have taken place, both face to face and with delegates joining via MS Teams.

The Board of Directors may request the Chairman to seek the views of the Council of Governors on any matters it may determine. Communications and consultations between the Council of Governors and the Board include, but are not limited to the following topics:

- our annual plan
- the Board's strategic proposals
- clinical and service priorities
- proposals for new capital developments
- engagement of our membership and the public.

The Board of Directors presents the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors.

Detailed information on the composition of our Council of Governors can be found in the tables ~~below~~overleaf.

| Public constituencies | | | |
|---|---|---|---|
| Name | Constituency | Tenure | CoG Attendance |
| Dave Cawley | South Hams and Plymouth | Elected – 01 March 2022 | 3 (4) |
| Craig Davidson | South Hams and Plymouth | Re-elected – 01 March 2022 | 3 (4) |
| Val Browning | South Hams and Plymouth | Elected - 01 March 2023 | 0 (0) |
| *Jean Thomas | Teignbridge | Elected – 01 March 2021 | 4 (4) |
| Loveday Densham | Torbay | Elected – 01 March 2021 | 4 (4) |
| Steven Harden | Torbay | Elected – 01 March 2020<br>(Did not stand for re-election – completed term of office on 28.02.2023) | 2 (4) |
| Eileen Engelmann | Teignbridge | Re-elected – 01 March 2022 | 4 (4) |
| Annie Hall | Teignbridge | Re-elected – 01 March 2022 | 3 (4) |
| Michael James | Teignbridge | Re-elected – 01 March 2022 | 1 (4) |
| John Smith | Teignbridge | Re-elected – 01 March 2022 | 3 (4) |
| Jan Goodman | Teignbridge | Elected – 01 March 2023<br>Resigned – 01 August 2022 | 1 (1) |
| Andrew Postlethwaite | Teignbridge | Elected – 01 March 2023 | 0 (0) |
| James Hartley | Teignbridge | Elected – 01 March 2023 | 0 (0) |
| *Andrew Stilliard | Torbay | Elected – 01 March 2020<br>Re-elected – 01 March 2023 | 2 (4) |
| John Kiddey | Torbay | Elected – 01 March 2020<br>(Stood but was not re-elected in 2023 round of elections, however took over the remaining term left vacant by Mark Tyrell-Smith as the candidate with the next highest number of votes) | 4 (4) |
| Keith Yelland | Torbay | Elected – 01 March 2021 | 3 (4) |
| Mark Tyrrell-Smith | Torbay | Elected 01 March 2021<br>Resigned – 10 June 2021<br>(moved out of Teignbridge consistency)<br>Re-elected 01 March 2022<br>Resigned – 28 February 2023 | 4 (4) |
| Peter Milford | Torbay | Elected – 01 March 2022 | 4 (4) |
| Alison Ramon | Torbay | Elected – 01 March 2023 | 0 (0) |
| Lee Thomas | Torbay | Elected – 01 March 2023 | 0 (0) |
| *Appointed 04 May 2022: Lead Governor, Jean Thomas, Deputy Lead Governor Andrew Stilliard | | | |

| Staff-elected governors (staff constituency), six representatives (two vacancies) | | | |
|---|---|---|---|
| Name | Class | Tenure | CoG Attendance |
| Matthew Giles (Nee Arthur) | Paignton and Brixham ISU | Elected – 01 March 2021 | 1 (4) |
| Emily Wood (Nee Huggins) | Trustwide Operations and Corporate Services ISU | Elected – 01 March 2021 | 2 (4) |
| Radia Woodbridge | Moor to Sea ISU | Elected – 01 March 2021 | 3 (4) |
| Sal Aziz | Torquay ISU | Elected – 01 March 2023 | 0 (0) |
| Johnathan Shribman | Newton Abbot ISU | Elected – 01 March 2023 (previously Governor for South Hams and Plymouth for one term) | 2 (4) |
| *Vacancy* | Coastal ISU | | |
| Deborrah Kelly | Torquay ISU | Elected – 01 March 2023 Resigned 18 October 2022 | 2 (2) |

| Appointed governors (partner organisations) | | | |
|---|---|---|---|
| Name | Organisation | Tenure | CoG Attendance |
| Derek Blackford | Devon CCG | Re-appointed – 01 April 2020 | 1(4) |
| Jonathan Hawkins | Devon County Council | Appointed – 14 May 2019 | 2 (4) |
| Nicole Amil | Torbay Council | Re-appointed – 01 October 2020 | 4(4) |
| Rosemary Rowe | South Hams District Council | Appointed – 25 July 2019 (did not stand for reappointment in local council elections) | 3 (4) |
| Lorraine Evans | Teignbridge District Council | Appointed 18.06.2019 Resigned August 2022 | 0 (2) |
| Chrissie Thirwell | University of Exeter Medical School | Appointed 01 March 2023 | 0 (0) |
| Andrew MacGregor | Teignbridge District Council | Appointed 01 March 2023 | 0 (0) |
| Clare McAdam | South Hams District Council | Appointed 01 March 2023 | 0 (0) |
| Louise Winfield | Plymouth University Peninsula Schools of Medicine and Dentistry | Appointed 01 March 2023 | 0 (0) |
| Hilary Milner | Devon Carers | Appointed 01 March 2023 | 0 (0) |

## Governor elections

In order to refresh the Council of Governors and bring a diverse range of views ~~in~~ ~~to~~into our organisation, elections are held every year. These elections are held in the various geographical or staff constituencies as set out in our constitution. During this year, the following elections were held with each member being offered a three-year term of office.

| Constituency | Candidate | Result | Voting % |
|---|---|---|---|
| Torbay | Alison Ramon | Elected | 16.1% |
| Torbay | Andrew Stilliard | Elected | |
| Teignbridge | James Hartley | Elected | 13.6% |
| Teignbridge | Andrew Postlethwaite | Elected | |
| South Hams & Plymouth | Val Browing | Elected unopposed | N/A |
| Staff Governor (Newton Abbot ISU) | Jonathan Shribman | Elected unopposed | N/A |
| Staff Governor (Torquay ISU) | Sal Aziz | Elected unopposed | N/A |

## Governors' interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as governors. Our membership office maintains a register of interests which is published on our website.

## Committees of the Council of Governors

The Council of Governors has appointed one standing Committee and one working group. ~~These are:~~Further information on these can be found below.

## Governors' Nomination and Remuneration Committee

The Governors' Nomination and Remuneration Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, our constitution, and the NHS Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to appointments, remuneration and other terms of service of the Chairman and Non-Executive Directors. Its functions include:

- to receive advice as directed by the regulator and determine overall remuneration and terms and conditions of service for the Chairman and Non- Executive Directors
- to recommend to the Council of Governors the levels of remuneration and terms and conditions of service for Chairman and Non-Executive Directors
- to monitor the performance of the Non-Executive Directors through the Chairman
- to monitor the performance of the Chairman through the Senior Independent Director
- to undertake a periodic review of the numbers, structure, and composition (including the person specifications) of the Chairman and Non-Executive
- Directors, to reflect the expertise and experience required, and to make recommendations to the Council of Governors
- to develop succession plans for the Chairman and Non-Executive Directors, considering the size and composition of the organisation
- identify and nominate candidates to fill the Chairman and Non-Executive Director posts as they arise.

The Committee met eight times during the year to consider remuneration levels for Non-Executive Directors, re-appointment of the Chairman and Non-Executive Directors, determine the process for appraising the performance of the Chairman and Non-Executive Directors and reviewed the succession plan for Non-Executive Directors. In considering the remuneration levels and the performance appraisal process, the Committee took in to account the guidance issued by NHSE and ensured processes were in line with that guidance. The Committee also undertook a self-assessment of its effectiveness and reviewed its terms of reference.

## Membership Committee

The Membership Committee is a formal Committee established in accordance with our constitution for monitoring, maintaining, and advancing the membership. Its primary purpose is:

- advice by offering advice and information to the Council of Governors on the community perception of our conduct of our healthcare provision
- recruitment by seeking to maintain the registered membership at its present level and to maintain under review means of achieving a representation of all sectors of the community
- information by promoting a series of seminars and events for members and members of the public, focusing on significant sectors of our work
- engagement by promoting communications to and from members.

The Committee continued to meet virtually during 2022/23, using MS Teams. Limited person and face-to-face engagement with members took place with email and social media being the primary means of communication and engagement in 2022/23.

## Membership and meetings of the Council of Governors

Membership is free and aims to give local people and staff a greater influence over how our services are provided and developed. It also helps us to work much more closely with local people and the people who use our services. Our members have the chance to find out more about the hospitals, our community services, the way they are run and the challenges they face, and furthermore, help us work with local people to improve the care and experience of patients and their carers'.

We had 15,344 members as at 31 March 2023, split between 8, 128* public members and 7,216 staff members. The public ~~constituiencies~~constituencies of South Hams and Plymouth. Teignbridge, Torbay and Rest of the South West Peninsula comprised 967 members, 2,999 members, 4,058 member and one member, respectively. Public membership is open to people aged 14 or over and who live within our defined membership area. During the reporting year, a data cleanse exercise was undertaken which provided members with the opportunity to check and update the details we hold for them. All eligible staff automatically become staff members unless they choose to opt out. Staff are eligible for membership provided that they hold a permanent contract of employment with us or they have been employed by us on a temporary contract of 12 months or longer.

(*There is a discrepancy of 103 between the total number of public members and members in each public constituency. This is due to the constituency data being requested after the year end reflecting changes in membership numbers)

The Council of Governors met on a total of four occasions during 2022/23. In the reporting period, the majority Council of Governors meetings have been held virtually, via MS Teams. A virtual Annual Members' Meeting was held at which the Annual Report was presented to the governors by the Board.

During 2022/23 the Council of Governors held two formal meetings with our Board of Directors. Following a review of meetings as part of the Council of Governor's work to review its structure, supported by the Good Governance Institute, the decision was made to stand down formal Board to Council of Governors meetings. These have been replaced with informal bi-monthly 'Council of Governor Priorities' meetings, which Non-Executive and Executive Board members are invited to attend at the Governor's discretion depending on the matters being discussed.

### Performance of the Council of Governors

The Council of Governors is required to undertake a regular self-assessment of its performance year to establish whether it has adequately and effectively discharged its role, functions, and duties during the preceding year. During 2022/23 the Council of Governors undertook a series of workshops, supported by the Good Governance Institute to improve the function of the Council and Governors. This included a self-assessment exercise. Following the workshops an action plan was developed and continues to be implemented.

### **NHS oversight framework**

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

### Segmentation

On 22nd November 2022, it was confirmed that we have now been placed into OF segment 4 from segment 3 and would therefore receive further bespoke mandated support. The reason for the segment 4 rating was our underlying financial deficit and operational performance improvement requirements.

In response to our segment four rating, we are developing a series of timebound and measurable performance obligations to exit segment 4. These have been agreed with ICB Devon and NHSE. Progress against the exit criteria is BEING regularly scrutinised through our governance processes and reported monthly to the system improvement and assurance group.

This segmentation information is the trust's position as at 28 June 2023. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

## Well Led [NEW SECTION TO BE ADDED]

[2.28 NHS foundation trusts are required to include in the directors' report a section which gives a brief overview of the arrangements in place to ensure that services are well-led.12 This should provide information or signpost the reader to where the trust's approach to ensuring services are well led is discussed in more detail in the annual report (eg in the annual governance statement or performance report). The section should summarise briefly:

• how the foundation trust has hadThe Trust has due regard to the well-led framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework, and a summary of action plans to improve the governance of qualitycontrols and board assurance framework. Its principles also underpin our strategy, approach to risk management and are utilised to review Board and Committee effectiveness. Greater detail of our approach with regard to clinical services can be found within our Quality Account 2022/23 and more broadly within this Annual Report; notably within the Performance Report and Governance Statements; which explore both our performance and governance framework more broadly.

• material inconsistencies (if any) between:
o the annual governance statement
o the corporate governance statement13, and annual report and
o reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.]

During the reporting period 2022/23, we had no formal CQC inspections but continued to work in partnership with the CQC via our regular planned contact. This scheduled activity includes our monthly CQC meetings with our local inspector and inspection manager as well as the quarterly engagement meetings. These meetings have executive involvement and are a good vehicle for open discussion and sharing between ourselves and the CQC.

We also continued our audit and assurance work to ensure risk assessments were completed for each patient within 24 hours of admission to hospital and in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken.

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an integrated service unit (ISU) level, as well as at the nutritional steering group and by exception to the quality improvement group.

## Patient Care ~~[NEW SECTION TO BE ADDED]~~

~~[descriptions of how the NHS foundation trust is using its foundation trust status to develop its services and improve patient care~~
~~•~~ Our Quality Goals, expanded upon within our Quality Account 2022/23 outlines our commitment and strategy for improved, personalised, patient care. Our Quality Goals for 2022/203 were:

Quality priority one: improve identification and management of sepsis
Quality priority two: improve compliance around patient risk assessments
Quality priority three: improved identification of deteriorating patient
Quality priority four: improved experience for people being discharged

Assessment of our progress and performance against ~~key healthcare targets~~
~~• arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and the NHS foundation trust's response to any recommendations made~~
~~• progress towards targets~~these is referred to within the Performance report as ~~agreed with local commissioners, together with details of other key quality improvements~~
~~• any new or significantly revised services~~
~~• service improvements following staff or patient surveys/ comments and Care Quality Commission reports~~
~~• improvements~~well as being explored in more detail in ~~patient/carer information~~our Quality Account 2022/23.

~~• information on complaints handling.]~~

## Stakeholder relations

In addition to our partnership working, we engage directly with other stakeholders including our patients, service users, carers, families, and the public to understand, listen and where possible adapt or change the services we offer and recognise the value of their ideas about these how services can be developed and improved.

Our Board of Directors recognises the importance of understanding the experiences of people who use our services and continues its commitment to receive a story regularly at Board meetings.

With such a large public membership, this allows the organisation to harness and utilise the experience of our members, who provide us with knowledgeable information. Our governors attend our Board sub-committee's as observers and patient representatives also attend important groups such as the patient feedback and engagement group, quality improvement group and mortality surveillance group, so that we can better understand the experiences and needs of people who use our services.

Information and feedback are received from many quarters including national surveys and local surveys. We resumed the Friends and Family Test and aim to resume real time inpatient experience survey soon which is led by our working with us volunteers and supported through clinical effectiveness and consultations. These provide a rich source of data and with the national surveys provide benchmark data we can use for comparisons. We also receive valuable ideas and suggestions from well-established patient pathways, social media and our patient and service user groups.

We also work with external organisations such as Healthwatch and seAp (a charity providing independent and confidential advocacy services), both of which help us hear the voices of people who use our services more clearly. We are committed toworking in partnership to improve how we listen to, and use, people's experiences to improve our services.

The Council of Governors' Membership Committee, ~~focuses~~focusses on ensuring there is an ongoing dialogue with members and that we continue to develop the membership to make it as representative ~~as possible~~ of the whole community~~.~~ as possible. Public membership at the end of March 2022 totalled 8,721 and 8,128 at the end of March 2023. Members of the public, living in any of the three public constituencies and aged over 14, are eligible to become members.

## Other disclosures

### Fees and charges (income generation)

Costs associated with fees and charges levied by the organisation are set out in note 5 to the annual accounts.

### Income disclosures required by Section 43(2A) of the NHS Act 2006

As disclosed in the Foundation Trust's annual accounts, the Foundation Trust complies with the need to ensure that income from the provision of goods and services for health services in England is greater than its income from the provision of goods and services for any other purpose; Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

The other income that the Foundation Trust receives either fully covers the cost of those services or for income generating activities, profit is directly reinvested into the provision of health and social care.

### Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement & NHS England.

### Better payment code of practice

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

No payments were made during the year (2020/21: £Nil) under the Late Payment of Commercial Debts (Interest) Act 1998.

| | 2022/23 | | 2021/22 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total Non-NHS trade invoices paid in the year | 143,838 | 325,511 | 145,108 | 286,203 |
| Total Non-NHS trade invoices paid within target | 117,653 | 268,218 | 123,927 | 240,117 |
| Percentage of Non-NHS trade invoices paid within target | 82% | 82% | 85% | 84% |
| | | | | |
| Total NHS trade invoices paid in the year | 1,849 | 31,540 | 2,093 | 26,773 |
| Total NHS trade invoices paid within target | 943 | 25,455 | 1,113 | 20,663 |
| Percentage of NHS trade invoices paid within target | 51% | 81% | 59% | 77% |

### Counter fraud policies and procedures

We have a clear strategy for tackling fraud, corruption and bribery. This is documented in our counter fraud, bribery and corruption policy which details responsibilities and how to report suspicions of fraud, bribery or corruption.

We have a lead accredited Local Counter Fraud Specialist (LCFS) via consortium arrangements with ASW Assurance. In addition, we have a number of nominated support personnel from within the consortium that are able to support the organisation as required. The LCFS ensures risks are mitigated and systems are resilient to fraud, corruption and bribery. An annual counter fraud work plan is reviewed and approved by the Audit and Risk Committee.

The Deputy Chief Executive and Chief Finance Officer and the Audit Committee oversee the work of the LCFS. Reports on progress with delivery together with outlines of referrals received and investigations are regularly provided to the Audit Committee. The LCFS also highlights to the Committee any issues that have arisen so that appropriate action can be taken.

The program of counter fraud work was delivered in 2022/23 addressing all components of the Government Functional Standard GovS 013: Counter Fraud and NHS Counter Fraud Authority strategy. The LCFS develops and maintains key relationships across the organisation and this, coupled with the work undertaken by the LCFS, has resulted in the development of a strong anti-fraud culture.

### Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement and NHS England.

## Accessible Information Standard

### Making health and social care information accessible

From 01 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Healthwatch in Devon, Plymouth, and Torbay is the independent consumer champion for health and social care services, ensuring the voice of the community is used to influence and improve services for local people. They worked with the local deaf community and undertook an independent review of NHS services across Devon to ascertain how accessible their services were to them. They provided recommendations and suggestions for improvement and in response an action plan is being developed which will entail collaboration with the deaf community and other key partners.

## Statement as to Disclosure to Auditors (s418)

- The Board of Directors reports that for everyone who is a director at the time this report is approved: as far as the director is aware, there is no relevant audit information of which our auditor is unaware
- the director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that our auditor is aware of that information.
- Relevant audit information' means information needed by our auditor in connection with preparing their report. A director is regarded as having taken all the steps that they ought to have taken as a director to do the things mentioned above, and:
- made such enquiries of their fellow directors and of the corporation's auditors for that purpose
- taken such other steps (if any) for that purpose, as are required by their duty as a director of the company to exercise reasonable care, skill, and diligence.

The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the organisation's performance, business model and strategy.

Liz Davenport
, Chief Executive
28 June 2023

## PART III – REMUNERATION REPORT

Salary and pension entitlements of senior managers as at 31 March 2023 (audited information)

| | 2021-22 | | | | | | 2022-23 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Salary | Expense Payments (taxable) | Annual Performance Pay and Bonuses | Long-term Performance Pay and Bonuses | All Pension Related Benefits | Total | Salary | Expense Payments (taxable) | Annual Performance Pay and Bonuses | Long-term Performance Pay and Bonuses | All Pension Related Benefits | Total |
| | (bands of £5,000) | (to nearest £100) | (bands of £5,000) | (bands of £5,000) | (bands of £2,500) | (bands of £5,000) | (bands of £5,000) | (to nearest £100) | (bands of £5,000) | (bands of £5,000) | (bands of £2,500) | (bands of £5,000) |
| **Name and Title** | £000 | £ | £000 | £000 | £000 | £000 | £000 | £ | £000 | £000 | £000 | £000 |
| **Mrs L Davenport**<br>Chief Executive | 190-195 | 0 | 0 | 0 | 60-62.5 | 250-255 | 200-205 | 0 | 0 | 0 | 70-72.5 | 270-275 |
| **Mr D Stacey**<br>Chief Finance Officer and Deputy Chief Executive | 150-155 | 0 | 0 | 0 | 47.5-50 | 200-205 | 160-165 | 0 | 0 | 0 | 0 | 160-165 |
| **Dr R G Dyer**<br>Deputy Chief Executive<br>(retired 05 July 2021) | 55-60 | 0 | 0 | 0 | 0 | 55-60 | | | | | | |
| **Mr I Currie**<br>Executive Medical Director | 210-215 | 0 | 0 | 0 | 247.5-250 | 460-465 | 220-225 | 0 | 0 | 0 | 310-312.5 | 525-530 |
| **Ms D Kelly**<br>Chief Nurse | 125-130 | 0 | 0 | 0 | 0 | 125-130 | 130-135 | 0 | 0 | 0 | 0 | 130-135 |
| **Ms A Jones**<br>Director of Transformation and Partnerships | 120-125 | 0 | 0 | 0 | 5.0-7.5 | 130-135 | 125-130 | 0 | 0 | 0 | 30-32.5 | 160-165 |
| **Mrs J Falcão**<br>Director of Workforce and Organisational Development (retired 11 July 2022) | 120-125 | 0 | 0 | 0 | 35-37.5 | 155-160 | 30-35 | 0 | 0 | 0 | 5.0-7.5 | 35-40 |
| **Mr J Harrison**<br>Chief Operating Officer (executive duties ceased 17 October 2022) | 125-130 | 0 | 0 | 0 | 55-57.5 | 180-185 | 65-70 | 0 | 0 | 0 | 0 | 65-70 |
| **Dr J Watson**<br>Health and Care Strategy Director | 170-175 | 0 | 0 | 0 | 112.5-115 | 285-290 | 170-175 | 0 | 0 | 0 | 40-42.5 | 210-215 |
| **Mrs E Long**<br>Director of Corporate Governance and Trust Secretary | 35-40 | 0 | 0 | 0 | 10-12.5 | 45-50 | 25-30 | 0 | 0 | 0 | 27.5-30 | 50-55 |
| **Mr O Raheem**<br>Interim Director of Corporate Governance and Trust Secretary<br>(left 14 February 2023) | 10-15 | 0 | 0 | 0 | 7.5-10 | 20-25 | 75-80 | 0 | 0 | 0 | 25-30 | 105-110 |
| **Mr J Scott**<br>Interim Chief Operating Officer<br>(appointed 03rd October 2022) | | | | | | | 150-155 | 3,100 | 0 | 0 | 0 | 150-155 |
| **Ms ST Flavin**<br>Interim Chief People Officer<br>(appointed 07 June 2022, left 02 December 2022) | | | | | | | 95-100 | 0 | 0 | 0 | 0 | 95-100 |
| **Dr M Westwood**<br>Chief People Officer<br>(appointed 01 November 2022) | | | | | | | 50-55 | 0 | 0 | 0 | 7.5-10 | 55-60 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sir R Ibbotson** Non-Executive Chairman | 50-55 | 1,000 | 0 | 0 | | 50-55 | 50-55 | 2,500 | 0 | 0 | | 50-55 |
| **Mrs S Taylor** Vice Chair / Non- Executive Director(retired 31 December 2022)) | 15-20 | 0 | 0 | 0 | | 15-20 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mrs J Lyttle** Non-Executive Director and Senior Independent Director (SID until 31 December 2022) | 10-15 | 0 | 0 | 0 | | 10-15 | 15-20 | 0 | 0 | 0 | | 15-20 |
| **Mr J Welch** Non-Executive Director (Retired 30 September 2021) | 5-10 | 0 | 0 | 0 | | 5-10 | | | | | | |
| **Mr R Sutton** Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mr P Richards** Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Mrs V Matthews** Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Prof C Balch** Non-Executive Director | 10-15 | 0 | 0 | 0 | | 10-15 | 10-15 | 0 | 0 | 0 | | 10-15 |
| **Dr S Wollaston** Non-Executive Director (commenced 0**1 October 2021**, left 29 November 2021) | 0-5 | 0 | 0 | 0 | | 0-5 | | | | | | |
| **Mr R Crompton** Non-Executive Director (appointed 011st August 2022) | | | | | | | 5-10 | 0 | 0 | 0 | | 5-10 |
| **Ms S Walker- McAllister** Non-Executive Director (Appointed 011st September 2022) | | | | | | | 5-10 | 0 | 0 | 0 | | 5-10 |
| **Dr P Aitken** Associate Non-Executive Director (appointed 011st January 2023) | | | | | | | 0.0-5.0 | 0 | 0 | 0 | | 0.0-5.0 |

Notes:

Dr P Aitken was appointed on 011st January 2023
Mr R Crompton was appointed on 011st August 2022
Dr R G Dyer retired on 055 July 2021.
Dr J Watson's remuneration is inclusive of clinical, operational as well as Trust Board duties.
Mr O Raheem was appointed on 15 February 2022 as Interim Director of Corporate Governance and Trust Secretary, and left the Trust on 14 February 2023.
Ms J Falcão retired on 11 July 2022.
Ms S Flavin was appointed as Interim Chief People Officer on 077th June 2022 and left on 022nd December 2022.
Dr M Westwood was appointed on 041st November 2022 as Chief People Officer.
Mr J Harrison's Executive duties ceased on 17 October 2022.

Mr J Scott was appointed on the 033rd October 2022 as Interim Chief Operating Officer.
Mrs S Taylor retired on 31 December 2022
Mrs Siân Walker-McAllister was appointed on 011st September 2022
Mr J Welch retired on 30 September 2021
Mrs Emily Long (on maternity leave February 2022 to February 2023).
Dr S Wollaston was appointed on 011st October 2021 but left on 29 November 2021 to take up another NHS appointment.
The following have opted out of the pension scheme: Ms D Kelly before joining the trust, Mr J Scott and Ms S Flavin.
The taxable benefits are in respect of travel expenses that are subject to income tax. None of the Directors received any annual or long-term performance-related benefits.

Page 65 (page number changed will be updated in final version) refers to managers who are paid more than £142,500 per annum (not including pension related benefits).

## Pension benefits as at 31 March 2023 (audited information)

| Name and title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 1 April 2021 £000 | Real Increase / (Decrease) in Cash Equivalent Transfer Value £000 | Cash Equivalent Transfer Value at 31 March 2022 £000 | Employers Contribution to Stakeholder Pension (to nearest £100) £000 |
|---|---|---|---|---|---|---|---|---|
| **Mrs L Davenport**<br>Chief Executive | 2.5-5.0 | 0.0-2.5 | 90-95 | 200-205 | 1,779 | **91** | 1,954 | 0 |
| **Mr I Currie**<br>Executive Medical Director | 15-17.5 | 32.5-35 | 100-105 | 275-280 | 2,013 | **0** | 158* | 0 |
| **Mr D Stacey**<br>Chief Finance Officer and Deputy Chief Executive | 0.0-2.5 | 0 | 20-25 | 0 | 202 | **0** | 212 | 0 |
| **Ms A Jones**<br>Director of Transformation and Partnerships | 2.0-2.5 | 0.0-2.5 | 40-45 | 65-70 | 582 | **26** | 643 | 0 |
| **Mrs J Falcão**<br>Director of Workforce and Organisational Development (retired 11 July 2022) | 0.0-2.5 | 0 | 50-55 | 105-110 | 980 | **0** | 823** | 0 |
| **Mr J Harrison**<br>Chief Operating Officer (Executive duties ceased 17 October 2022) | 0-2.5 | 0 | 40-45 | 80-85 | 764 | **0** | 811 | 0 |
| **Mrs E Long**<br>Director of Corporate Governance and Trust Secretary | 0-2.5 | 0 | 0-5.0 | 0 | 7 | **10** | 21 | 0 |
| **Mr O Raheem**<br>Interim Director of Corporate Governance and Trust Secretary | 0-2.5 | 0 | 0-5.0 | 0 | 8 | **12** | 31 | 0 |
| **Dr M Westwood**<br>Chief People Officer (appointed 1st November 2022) | 0-2.5 | 0 | 0-5.0 | 0 | 0 | **1** | 8 | 0 |
| **Dr J Watson**<br>Health and Care Strategy Director | 2.5-5.0 | 0-2.5 | 65-70 | 130-135 | 1,227 | **55** | 1,337 | 0 |

*Mr I Currie CETV not required to be disclosed.
**Mrs J Falcão retired on 055th July 2021. At which point the pension began to be drawn. Accordingly, the CETV of Mrs Falcão's pension at 31 March 2023 is not available.
***Mrs Emily Long (on maternity leave February 2022 to February 2023).

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued because of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member because of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

## Annual Statement on Remuneration

There have been no changes to the remuneration policy for senior managers during the year.

For Executive Directors there are no arrangements relating to termination payments other than the application of employment contract law. No termination payments have been made to either present or past senior managers within 2022/23.

The Non-Executive Directors Nomination and Remuneration Committee (the Committee), whose function it is to decide pay for Executive Directors conduct a review of executive salaries each year.

During the year ending 31 March 2023, four senior managers (Chief Executive, CFO & Deputy Chief Executive, Medical Director and the Health & Care Strategy Director (including payment for role as a Consultant) were paid more than £142,500. The steps outlined above provides the Non-Executive Nominations and Remuneration

Committee with assurance that the remuneration level is reasonable and linked appropriately to the weight of the role based on accountability, job responsibilities and the knowledge and skills required for each of those positions.

Remuneration is set in accordance with NHS Agenda for Change for all staff other than doctors and directors. Pay and conditions of service for doctors is agreed nationally.

### Senior managers' remuneration policy

The remuneration package for senior managers consists of the following factors:

| Item | Rationale |
|---|---|
| **Salary** | Our strategy and business planning process set the key business objectives of our organisation which are delivered by the senior managers. This success measure is one of the ways in which the senior managers' performance is monitored.<br>Senior managers' remuneration is based on market rates and there are no automatic salary rises. To ensure that the pay and terms of service offered by the organisation are both reasonable and competitive, comparisons are made between the scale and scope of responsibilities of our senior managers and those of employees holding similar roles in other organisations.<br>A report is prepared for the Non-Executive Nominations and Remuneration Committee by the Chief People Officer, which makes these comparisons between our remuneration rates for senior managers and market rates.<br>The base salaries of Executive Directors in post at the start of the policy period and who remain in the same role throughout the policy period will not usually be increased by a higher percentage than the maximum incremental uplift applicable to the highest paid staff on Agenda for Change. The only exceptions are where an Executive Director has been appointed at below market level to reflect experience.<br>Senior managers are paid spot level salaries rather than on an incremental scale and may collectively receive an annual uplift in salary in line with '*Guidance on pay for very senior managers'* issued by NHSEI. |
| | All senior managers' remuneration is subject to satisfactory performance of duties in line with their employment.<br>There are no performance related pay so senior managers receive one hundred per cent of their salary subject to the relevant deductions. |
| **Taxable benefits** | The Non-Executive Nominations and Remuneration Committee agree any taxable benefit.<br>This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive.<br>There is no maximum amount payable. |
| **Pension** | Standard pension arrangements are in place in 2022/23.<br>This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive<br>There is no maximum amount payable. |
| **Bonus** | There is no bonus scheme for any senior manager, however bonus payments may be made on a discretionary basis subject to approval by the Non-Executive Nominations and Remuneration Committee.<br>All other staff, except the senior management team at Torbay Pharmaceuticals, are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally. |
| **Other** | Individual items such as lease cars are not offered as part of a remuneration package. Board level directors may, however, put forward an individual request in respect of such items.<br>Senior managers' terms and conditions e.g. holidays, pensions, sick pay are in accordance with Agenda for Change terms and conditions. |

## Senior manager's objectives and performance

Senior managers meet annually with the Chief Executive to agree core and individual performance objectives and subsequently meet with the Chief Executive monthly to discuss the progress made towards the targets set. A formal interim progress review is held six months after the objectives are set, a final review of performance and achievement of objectives is held at the end of the year, when objectives for the following year are also discussed and agreed.

The Chief Executive's performance is appraised using the same system, but their performance objectives are agreed with and monitored by the Chairman. This process was designed to ensure that clearly defined and measurable performance objectives are agreed, and progress towards these objectives is regularly and openly monitored, both formally and informally.

The Chief Executive presents an assurance report to the Committee each year outlining the appraisal process undertaken. The Committee also receives a summary report on the performance of each of the Executive Directors and Associate Directors and a recommendation in respect of any proposed changes to remuneration levels. The Chairman adheres to the same process in regard to the Chief Executive.

~~report on the performance of each of the Executive Directors and Associate Directors and a recommendation in respect of any proposed changes to remuneration levels. The Chairman adheres to the same process in regard to the Chief Executive.~~

## Remuneration of Executive Directors and other employees

When setting remuneration levels for the Executive Directors, the Nominations and Remuneration Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other Foundation Trusts of a similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader organisational workforce.

In particular, the Nominations and Remuneration Committee considers the recommendations of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration as reflecting most closely the economic environment encountered by Executive Directors. We do not consult more widely with employees on such senior managers' remuneration matters.

## Annual Report on remuneration

### Service contracts

The following table shows for each person who was an Executive or Associate Director or Non-Executive Director as at 31 March 2023, the commencement date for their current position and the term of service agreement or contract for services and details of notice periods.

| Director | Status | Contract start date | Contract term (years) | Unexpired term as at July 2023 | Notice period by the organisation | Notice period by the director |
|---|---|---|---|---|---|---|
| Mr I Currie | Executive Board member | 14.09.2020 | Indefinite terms | Not applicable | Three months | Three months |
| Ms L Davenport | Executive Board member | 01.10.2018 | Indefinite term | Not applicable | * | Six months |
| Mrs A Jones | Executive Board member | 22.07.2019 | Indefinite term | Not applicable | Three months | Three months |
| Ms D Kelly | Executive Board member | 01.08.2020 | Indefinite term | Not applicable | Three months | Three months |
| Mr J Scott** | Executive Board member | 18.10.2022 | 30.09.2023 | Not applicable | 24 hours | 24 hours |
| Mr D Stacey | Executive Board member | 06.01.2019 | Indefinite term | Not applicable | Three months | Three months |
| Dr J Watson | Executive Board member (non-voting) | 01.02.2020 | Indefinite term | Not applicable | Three months | Three months |
| Mrs E Long | Executive Board member & Trust Secretary (non-voting) | 01.11.2021 | Indefinite term | Not applicable | Three months | Three months |
| Dr M Westwood | Executive Board member | 27.11.2022 | Indefinite term | Not applicable | Three months | Three months |
| Sir Richard Ibbotson | Chairman & Non-Executive Board Member | 01.06.2021 | 1 year*** | 11 months | Three months | Three months |
| Mr C Balch | Non-Executive Board Member | 14.04.2022 | 3 years | 1 year and 8 months | Three months | Three months |
| Mrs J Lyttle | Non-Executive Board Member | 30.09.2020 | 1 year**** | 2 months | Three months | Three months |
| Mrs V Matthews | Non-Executive Board Member | 01.12.2020 | 3 years | 4 months | Three months | Three months |
| Mr P Richards | Non-Executive Board Member | 13.11.2020 | 3 years | 5 months | Three months | Three months |
| Mr R Sutton | Non-Executive Board Member | 01.05.2022 | 1 year ***** | 9 months | Three months | Three months |
| Mrs S Walker-McAllister | Non-Executive Board Member | 01.09.2022 | 3 years | 2 years and 2 months | Three months | Three months |
| Mr R Crompton | Non-Executive Board Member | 01.08.2022 | 3 years | 2 years and 1 month | Three months | Three months |
| Mr P Aitken | Associate Non-Executive Board Member (non-voting) | 01.01.2023 | 2 years | 1 year and 6 months | Three months | Three months |

Notes:
*as per statutory notice period i.e. one week for each year of employment up to a maximum of 12 weeks
** Mr J Scott is employed on an ongoing interim capacity on a bank contract of employment
***Sir Richard Ibbotson re-appointed for a fourth one-year term following two terms of office of three years
**** Mrs J Lyttle re-appointed for a third one-year term following two terms of office of three years.
***** Mr Sutton re-appointed for a second one-year term following two terms of office of three years
****** Mrs E Long, Maternity leave February 2022 – February 2023
Unless noted above, these officers have been in post throughout 2022/23

### Service contracts

As described above, senior managers contracts are open-ended (permanent) contracts. Non-Executive Directors serve terms of three years, up to a maximum of six years. The Council of Governors will consider and set terms of office for Non-Executive Directors beyond that point that meet the needs of the organisation, taking into account NHSE guidance and the NHS Code of Governance. Terms beyond that point should be set on an annual basis. Further details about the terms of office of each individual Non-Executive Director can be found in the Director's report within this annual report and accounts.

## Remuneration Committee Memberships and Meetings

Membership and details of meetings attendance can be found at page xx of this report.

We have established two Committees responsible for the remuneration, appointments and nominations of directors. A description of the Committee responsible for Non-Executive Director remuneration can be found in the section 'Committees of the Council of Governors'. The Committee responsible for the remuneration of Executive Directors is described below.

### The role of the Non-Executive Nominations and Remuneration Committee

The Non-Executive Nominations and Remuneration Committee ('the Committee') advises the Board on matters regarding the remuneration and terms of service for Executive Directors and senior managers. The Committee is established for the

purpose of overseeing the recruitment and selection process for Executive Directors and Associate Directors i.e. senior managers, and the appointment of formal Board positions, for example the Senior Independent Director. The Committee's second purpose is to determine the remuneration and terms of service of Executive Directors and Associate Directors.

The term 'senior managers' covers our employees in senior positions, who have authority and responsibility for directing and controlling major organisational activities. These employees influence the decisions of the entire organisation, meaning that the definition covers the Chief Executive and Board-level directors.

The advice offered covers all aspects of salary, including performance-related pay and bonuses, as applicable, pensions, provision of cars, insurance, and other benefits. Advice on arrangements for termination of contracts and other general contractual terms also falls within the remit of the Committee. Specifically, the Committee is charged with:

- advising on appropriate contracts of employment, including remuneration, for senior managers
- monitoring and evaluating the performance of individual senior managers
- making recommendations regarding the award of performance-related pay, based on both the organisation's performance and the performance of individuals
- advising on the proper calculation of any termination payments.

The Committee is empowered to obtain independent advice as it considers necessary. At all times, it must have regard to our performance and national arrangements for pay and terms of service for senior managers.

The Committee meets several times a year, to enable it to make its recommendations to the Board. It formally reports to the Board, explaining its recommendations and the basis for the decisions it makes.

The Committee's membership did not change during the year remained the Chairman, Vice-Chair, Senior Independent Director and the Chair of the People Committee. The Chief Executive and other senior managers should not be present when the Committee meets to discuss their individual remuneration and terms of service but may attend by invitation from the Committee to discuss other staff's terms. Accordingly, the Chief Executive and the Chief People Officer attend the Committee when required. The Trust Secretary attends the Committee in an advisory capacity.

### Chairman and Non-Executive Director remuneration

The Chairman's and Non-Executive Director's remuneration is overseen by the Governors' Nominations and Remuneration Committee ('Committee') as outlined in the Accountability Report 'Committees of the Council of Governors' section.

The Committee makes recommendations to the Council of Governors on the Non-Executive Directors and Chairman's remuneration levels, noting the NHSE guidance as published from time to time. The Chairman and Non-Executive Directors receive spot level remuneration but can claim reasonable expenses, for example travel expenses, as per other employees.

A review of remuneration levels applicable to Non-Executive Directors and the Chairman was undertaken during the year. The Committee was cognisant of the new remuneration framework and took the decision to maintain current levels of remuneration. Some Non-Executive Directors receive an additional one-off responsibility allowance based on Board positions held. No uplift in responsibility allowances was made during 2022/23.

The remuneration package for the Chairman and other Non-Executive Directors is made up of:

| Item | Rationale |
|---|---|
| **Remuneration** | £51,000 per annum for the Non-Executive Chairman - three days per week |
| **Remuneration** | £13,500 per annum for all other Non-Executive Directors - three days per month |
| **Remuneration** | Additional responsibility allowance of £3,000 for the Chair of the Audit Committee |
| **Remuneration** | Additional responsibility allowance of £1,500 given to the Senior Independent Director (SID) |
| **Remuneration** | Additional responsibility allowance of £1,000 given to the Vice Chair |
| **Expenses** | Chairman and Non-Executive Director mileage rates are aligned with latest guidance: 56p per mile for the first 3,500 miles reducing to 20p per mile thereafter. All other expenses remain in line with organisational policy. |

~~Policy on payment for loss of office for senior managers~~

~~Senior managers are employed on substantive contracts of employment and are employees of the organisation. Their contracts are open-ended employment contracts which can be terminated by either party by giving notice in accordance with their individual service contract.~~

~~Our normal disciplinary policy applies to senior managers, including the sanction of instant dismissal for gross misconduct. Our redundancy policy is consistent with the NHS redundancy terms for all staff.~~

## Governors' expenses

Governors may be reimbursed for legitimate expenses, incurred during their official duties, as governors of the Torbay and South Devon NHS Foundation Trust.

During the financial year, Governors were paid expenses to reimburse costs incurred while attending meetings of the Foundation Trust and at external training and development events.

| | 31 March 2022 | 31 March 2023 |
|---|---|---|
| Number of Governors in office | 26 | 31 |
| Number of Governors receiving expenses | 1 | 3 |
| Total expenses paid to Governors | £18.00 | £260.20 |

Note: Due to the COVID-19 pandemic very few face to face meetings were held in 2021/22, hence the unusually low level of expenses paid to governors in that year.

## Fair pay multiple (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in Torbay and South Devon NHS Foundation Trust in the financial year 2022/23 was £360,000 - £365,000 (2021/22, £210,000 - £215,000). This was 10.9 times (2021/22, 6.8) the median remuneration of the workforce, which was £32,919 (2021/22, £31,534).

The increase in ratio from 6.8 to 10.9 in 2022/23, is ~~mainly~~ due to a change in highest paid director and a salary increase in comparison to the previous highest paid director in 2021/22 ~~by 70%. Furthermore, there have been increases in the mid-point salary of 4.4%, and in lowest Agenda for Change (AfC) band of 9.3%.~~. The current highest paid director is the Interim Chief Operating Officer who is employed on a fixed term contract to fill a short notice vacancy. The Trust has required to temporarily extend this contract following an unsuccessful first recruitment round.

In 2022/23, 0 (2021/22, 3) employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £20,270 to £360,000 (2021/22, £18,546 - £262,188).

Total remuneration includes salary and non-consolidated performance-related pay. It does not include benefits-in-kind, severance payments, employer pension contributions and cash equivalent transfer value of pensions.

The median calculation is based on the full-time equivalent staff of the Foundation Trust at the reporting period end date on an annualised basis.

## Fair pay multiple (audited information) – 25th and 75th Percentile

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2022/23 was £360,000 - £365,000 (2021/22, £210,000 - £215,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the ~~below~~ table overleaf.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the trust as a whole, remuneration ranged from £20,270 to £360,000 in 2022/23 (2021/22, £18,546 to £262,188).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2%.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

| | 2022/23 | | | 2021/22 | | |
|---|---|---|---|---|---|---|
| | 25th Percentile | Median | 75th Percentile | 25th Percentile | Median | 75th Percentile |
| Salary component of pay | £23,177 | £32,919 | £41,659 | £21,777 | £31,534 | £39,042 |
| Total pay and benefits excluding pension | £23,177 | £32,919 | £41,659 | £21,777 | £31,534 | £39,042 |
| Total pay and benefits excluding pension: pay ratio for highest paid director | 15.5:1 | 10.9:1 | 8.6:1 | 9.8:1 | 6.7:1 | 5.4:1 |

## Definition of 'senior managers'

The definition of 'senior managers' is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. This includes the Chief Executive, Chairman, Executive, Associate and Non-Executive Directors. This definition covers all those who hold or have held office as Chairman, Non-Executive Director, Executive Director, or Associate Director of the organisation during the reporting year. It is irrelevant that:

- an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment)
- an individual's title as director included a prefix such as 'interim, acting, temporary or alternate'
- an individual was engaged via a corporate body, such as an agency, and payments were made to that corporate body rather than to the individual directly.

Policy on payment for loss of office for senior managers

Senior managers are employed on substantive contracts of employment and are employees of the organisation. Their contracts are open-ended employment contracts which can be terminated by either party by giving notice in accordance with their individual service contract.

Our normal disciplinary policy applies to senior managers, including the sanction of instant dismissal for gross misconduct. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

This concludes the Renumeration Report for 2022/2023.

Liz Davenport
, Chief Executive
28 June 2023

# PART IV – Staff report

## Analysis of staff costs (audited information)

The Foundation Trust is required to provide an analysis of staff costs, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other staff'.

| | 2022/23 | | | 2021/22 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently employed | Other | Total | Permanently employed | Other |
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Salaries and wages | 263,711 | 263,257 | 454 | 232,433 | 231,436 | 997 |
| Social security costs | 24,679 | 24,679 | - | 21,588 | 21,588 | - |
| Apprenticeship levy | 1,208 | 1,208 | - | 1,125 | 1,125 | - |
| Employer's contributions to NHS pensions | 29,588 | 29,588 | - | 27,827 | 27,827 | - |
| Pension cost – Employer contributions paid by NHSE/ NHSI on Trust's behalf (6.3%) | 12,985 | 12,985 | - | 12,199 | 12,199 | - |
| Pension cost - other | 59 | 59 | - | 50 | 50 | - |
| Temporary staff | 14,513 | - | 14,513 | 13,247 | - | 13,247 |
| **Total staff costs** | **346,743** | **331,776** | **14,967** | **308,469** | **294,225** | **14,244** |
| Of which: Costs capitalised as part of assets | 3,373 | 3,373 | - | 2,608 | 2,608 | - |

We incurred £376,000 (2021/22 £85,000) in respect of other post-employment benefits, other employment benefits, or termination benefits. We did not second any staff in either year to other organisations, instead where staff were supplied to other organisations we generated an income from this service.

## Analysis of worked full time equivalents (FTEs) (audited information)

We are required to provide an analysis of average staff numbers, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other' staff.

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating whole time equivalent number is used, that is, dividing the contracted hours of each employee by the standard working hours. Staff on outward secondment are not included in the average number of employees.

| NHSI Staff Group | 2022/23 Total | 2022/23 Of which permanently employed | 2022/23 Of which other | 2021/22 Total |
|---|---|---|---|---|
| Allied Health Professionals | **517** | *506* | *11* | **523** |
| Health Care Scientists | **93** | *92* | *1* | **93** |
| Medical and Dental | **566** | *1,115* | *47* | **574** |
| NHS Infrastructure Support | **1,162** | *273* | *293* | **1,151** |
| Other Scientific, Therapeutic and Technical Staff | **345** | *327* | *18* | **348** |
| Registered Ambulance Service Staff | **11** | *11* | *0* | **10** |
| Registered Nursing, Midwifery and Health Visiting Staff | **1,348** | *1,318* | *31* | **1,292** |
| Support to Clinical Staff | **1,973** | *1,840* | *133* | **1,897** |
| **Total** | **6,016** | ***5,482*** | ***534*** | **5,887** |

** Figures as at 03 April 2023*

## Analysis of sickness absence

We continue to develop the overall health and wellbeing of our people and our management of sickness absence. The sickness absence rate for 2022/23 compared to the previous five years is shown below. As was the case in the previous financial year, absence related to COVID-19 was a key contributor to the levels of sickness witnessed in the year.

| Year | 12 month sickness | Average FTE | FTE days available | FTE days lost to sickness | Average sickness absence duration (FTE days) |
|---|---|---|---|---|---|
| 2017/18 | 4.09% | 5,163 | 1,884,585 | 77,054 | 9.2 |
| 2018/19 | 4.23% | 5,177 | 1,889,505 | 79,859 | 9.5 |
| 2019/20 | 4.45% | 5,410 | 1,974,776 | 87,942 | 10.0 |
| 2020/21 | 4.02% | 5,667 | 2,068,557 | 83,152 | 9.0 |
| 2021/22 | 5.02% | 5,806 | 2,119,241 | 106,286 | 11.3 |
| 2022/23 | 5.27% | 6,027 | 2,199,716 | 115,864 | 11.9 |

Note: Source: from the Electronic Staff Record (ESR)

- period covered: April 2022 to March 2023 (Data as at 03 April 2023)
- data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year
- the number of Full-Time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to an average FTE in the third column by dividing by 365
- the number of FTE days lost to sickness absence has been taken directly from ESR
- the average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

## Analysis of staff turnover

Information showing our staff turnover data can be accessed via the following link to the NHS Digital website NHS workforce statistics - NHS Digital

## Staff policies and actions applied during the year

We continue to be committed to providing an inclusive environment for our patients, staff and visitors. We believe in providing equity in our services, in treating people fairly with respect and dignity and in valuing diversity both as a health and care services provider and as an employer.

Our diversity and inclusion policy set out the responsibilities of the organisation, our staff and people who use our services. We actively promote a culture that values difference and recognises that people from different backgrounds and experiences bring valuable knowledge and insights to the workplace and enhances the way we work. We strive to be inclusive, to value, respect and embed diversity in all areas across the organisation. This will support us to recruit and retain a diverse workforce that reflects the communities we serve. Our diversity and inclusion policy afford equal protection to those who access our services, ensuring people are involved in their care and our workforce, ensuring our people have fair and equal opportunity.

We are committed to compliance with the Equality Act 2010, and as part of the subsequent Public Sector Equality Duty, we are dedicated to:

- eliminating discrimination
- promoting equality of opportunity
- fostering good relations.

All our policies continue to be subject to a rapid or full (E) quality impact assessment which aims to tackle discrimination or disadvantage at the outset.

Employability activity supports those who may experience disadvantage to find sustainable employment through experience-based work placements. We support a range of people to develop their employability skills in a safe environment through our work experience programmes, traineeships if appropriate, apprenticeships and eventually through securing employment. We have created a stronger local network with the voluntary sector and DWP to work together on improving access to employment.

We have also joined the disability confident initiative (this replaced the √√ (2 ticks) scheme) and we are a disability committed employer who aims to progress to level two disability confident status in 2023/24

One in three of our people are unpaid carers (source: National Staff Survey 2022) and during this year, we have enhanced our support for staff who are juggling working with caring for a family member or friend. It is now firmly embedded within wellbeing with our wellbeing buddies receiving training in carer awareness. Access to support has been made simpler and managers who support staff carers have recently been recognised at our annual our people celebration event..

We continue to be a ‘Mindful Employer’, supporting health and wellbeing at work and this work continues to be reflected within our people promise. The plan is reflective of the national priorities, integrated care system (ICS) and organisational priorities. During the year our health and wellbeing programmes have focused on:

- successfully delivering our winter COVID and Flu vaccination programme and delivering the spring booster COVID programme
- we have been allocated monies via Charities Together to support our people's wellbeing specifically for:
- mental health training for managers. We worked with a local charity to provide the training both face to face and via MS Teams
- the development and support of our wellbeing buddy community including ~~mentall~~mental health first aider training. We currently have 250 wellbeing buddies
- focused wellbeing activities for specific staff groups to support their mental health
- our dedicated wellbeing week which focused on ‘looking after me’
- in line with our developing just and learning culture we reviewed and updated the following policies:
- wellbeing at work
- mental health and wellbeing
- domestic abuse
- misuse of alcohol and substances
- establishing a cost of living group which works closely with other key stakeholders eg Torbay Council to understand the impact on our people and actions to support
- undertaking a review of wellbeing using the National Health and Wellbeing Framework diagnostic tool in conjunction with our people promise and EDS2 to identify our priorities for 2023/24.

We recognise that there may be times when our people experience episodes of poor health and wellbeing and this is reflected in our National Staff Survey results. We have policies in place to ensure our people

get the support and guidance and reasonable adjustments they need to assist them through this difficult time. Our occupational health service is focused on the safety, health and wellbeing of our staff, patients and visitors.

We offer a full range of occupational health services, which are available to all our people including the following:

- health promotion as well as health information and advice
- health surveillance for employees identified as ‘at risk
- workplace assessments
- immunisation programmes
- training and policy advice
- infection control including ‘needlestick hotline’
- baseline screening for new employees.

We have recently commissioned a new Employee Assistance Programme (EAP) that staff can access themselves for a range of issues they may wish to seek support for, including physical and mental health as well as financial wellbeing. We advertise and promote this service widely to our people.

Our corporate health and safety team moved into our Workplace Team (formerly known as estates and facilities management). In conjunction with our Health and Safety Committee and with other relevant stakeholders and teams, our corporate health and safety team continue to develop a cultural improvement plan for organisational safety which focusses on training, individual accountability and improved reporting of hazards. In that spirit, additional learning is being rolled out

across the organisation in the form of Institute of Safety and Health (IOSH) Managing Safely training for all line managers. National Examination Board in Occupational Safety and Health (NEBOS) environmental training has also been provided to key people across our services to enhance our environmental safety focus.

We manage health and safety through a series of steering groups and committees which are attended by clinical and non-clinical colleagues, as well as relevant external consultants and regulators. These include the health and safety committee, the fire safety group, the asbestos safety group and the water safety group.

The anonymous digital communication platform Work In Confidence has been launched by our Freedom to Speak Up Guardian to give staff an alternative route to Speak Up. This enables our people to have a conversation with the Guardian without identifying themselves, this is proving successful and is being used both by individuals and teams. The platform is also being used to undertake anonymous surveys where concerns have been raised. This gives a temperature check and an opportunity for sharing experiences confidentially. The survey results are then shared with line managers to develop an appropriate action plan to help resolve the concerns, Proactive work to raise awareness through film, interactive platforms and face to face sessions continues as well as reactive work supporting both staff and managers in resolving concerns. The new national Freedom to Speak Up Policy will be launched alongside the new Patient Safety Incident Response Framework later in 2023.

Our Equality Business Forum (EBF) continues to provide the leadership for our network groups which include our disability network and our lesbian, gay, bisexual and transgender group (LGBTQ+). In addition to further reflect the diversity and needs of our people we also have an under 30s network, a menopause group, and a mental health group. Our BAME engagement group has significantly grown and now has more than 100 members. In addition, we have active representatives on the Devon-wide BAME network. Our EDI Lead in their capacity of system BAME network chair has presented to the Devon ICB Board sharing the experiences of our newly recruited international nurses. ~~Ournetwork~~Our network chairs attend our People Committee, which is a sub committee of our Board of Directors, to raise awareness of issues affecting ~~thir~~their members and provide assurance around how these are being addressed.

Whenever possible we continue to have an inclusivity representative on interview panels to ensure recruitment processes are inclusive. This also ensures we are growing a more inclusive and diverse future workforce and enabling the career progression for people from minority groups.

Through our evolving people promise plan, we have undertaken significant engagement with people from under-represented groups in order to better understand what is needed to ensure a culture of inclusion and belonging. The themes identified from this work together with the results of the staff survey have informed our work for 2022/23~~.~~; these included:

- the menopause network chair invites guest speakers who have specialist knowledge in the menopause to provide updates, raise awareness of symptoms and advice of what is available to support anyone going through the peri-menopause and are in menopause
- we are now providing training for a menopause mentor

- we are developing training about the peri-menopause and menopause for managers
- we promote and raise awareness of Ramadan, Diwali and other celebrations through articles, videos and offering diverse foods in our staff canteen
- we raised awareness through disability history month however unfortunately due to industrial action we had to postpone our planned disability conference
- we celebrated a highly successful Black History Month the highlight of which was a series of workshops with a national speaker. The workshops highlighted the journey of the NHS and the historic policies and procedures that it has inherited and the impact it has on us all now
- our overseas colleagues hosted a cultural event that included dancing, music, drumming and poetry and international foods
- we raised awareness of race equality through daily challenges on key topics designed stimulate personal reflection own bias and privilege
- 29 of our people completed our inaugural BME Leadership programme with several achieving promotion during this time
- We started to develop and co-design a training framework for managers to raise cultural awareness to ensure smooth the transition for international colleagues into their new team. Our international colleagues have been pivotal in designing this with us.

## 2023 national NHS staff survey

### Staff engagement and experience

We know that the best way to care for people who use our services is to care for the people who deliver those services – our dedicated, talented, compassionate staff. Supporting them to live well is central to enabling us to deliver our purpose – to support the people of Torbay and South Devon to live well.

Research evidences a clear relationship between people feeling seen, heard and valued and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality and safety measures, including infection rates.

The better we support and listen to our people, the better the outcomes and experience for people who use our services.

We have a range of well-established forums for our people to share their views and to engage with us including:

- Trust Talk – monthly briefing session from the Executive Team which is livestreamed, with opportunities for question and answers
- 'Just Ask!' noticeboard for people to ask questions or raise issues with the Executive Team
- staff surveys including the national annual staff survey and quarterly people pulse
- bespoke forums including the mental health forum and menopause group
- Freedom to Speak Up Guardian and champion network
- equality business forum and staff network groups
- joint consultations/negotiations with the Trade Unions
- wellbeing buddies
- staff governors.
-

## NHS staff survey

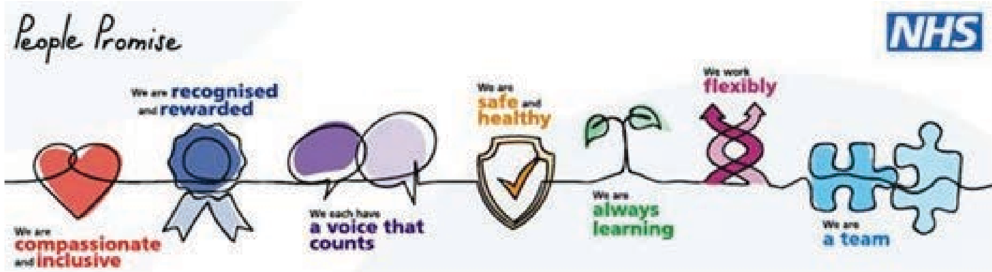
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS ‘People Promise’, and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The past 12 months has continued to challenge each and every one of our teams as we try to deliver better health and care for all and ensure that people waiting for care and treatment can be seen as quickly as possible.

The annual staff survey provides an incredibly helpful insight into the experience of our people at work. The survey is aligned to the NHS people promise which is based on what our people say matter to them most. As such, the survey feedback is presented in the form of nine elements – the seven people promises, together with two additional elements- staff engagement and staff morale. Each element receives a score from 0 to 10, with 10 being the best score attainable.

Regrettably, we saw a reduction in the overall response rate from 42% in 2021 to 38% in 2022. This compares to a median response rate of 44% for our benchmarking group - acute and acute and community trusts.

The feedback is presented below, together with the three previous reporting periods.




### 2022/23 and 2021/22

| Elements | Foundation trust 2022 | Benchmarking group | Foundation trust 2021 | Benchmarking group |
|---|---|---|---|---|
| We are compassionate and Inclusive | 7.2 | 7.2 | 7.2 | 7.2 |
| We are recognised and rewarded | 5.8 | 5.7 | 5.9 | 5.8 |
| We each have a voice that counts | 6.6 | 6.6 | 6.7 | 6.7 |
| We are safe and healthy | 5.8 | 5.9 | 5.9 | 5.9 |
| We are always learning | 5.2 | 5.4 | 5.1 | 5.2 |
| We work flexibly | 6.1 | 6.0 | 6.1 | 5.9 |
| We are a team | 6.7 | 6.6 | 6.7 | 6.6 |
| Staff engagement | 6.7 | 6.8 | 6.8 | 6.8 |
| Morale | 5.6 | 5.7 | 5.8 | 5.7 |

### 2020/21 and 2019/2020 – new reporting categories as of 2020/21

| | Foundation trust 2020/21 | Benchmarking group | Foundation trust 2019/20 | Benchmarking group |
|---|---|---|---|---|
| Equality, diversity and inclusion | 9.2 | 9.1 | 9.2 | 9.2 |
| Health and wellbeing | 6.1 | 6.1 | 6.1 | 6.0 |
| Immediate managers | 6.9 | 6.8 | 6.9 | 6.9 |
| Morale | 6.4 | 6.2 | 6.3 | 6.2 |
| Quality of appraisals | *Theme removed from reporting* | | 5.1 | 5.5 |
| Quality of care | 7.3 | 7.5 | 7.3 | 7.5 |
| Safe environment – bullying and harassment | 8.1 | 8.1 | 8.2 | 8.2 |
| Safe environment – violence | 9.5 | 9.5 | 9.5 | 9.5 |
| Safety culture | 6.6 | 6.8 | 6.6 | 6.8 |
| Staff engagement | 7.0 | 7.0 | 7.0 | 7.1 |
| Team working | 6.5 | 6.5 | 6.6 | 6.7 |

In comparison to last year, the feedback demonstrates that we have maintained or improved our performance in four of the nine elements: we are compassionate and inclusive, we are flexible, we are a team, we are always learning. It's important that we are all able to learn and flourish in our roles and we have seen the biggest improvement in our appraisal feedback. We have also seen an improvement in our flexible working feedback, which is hugely positive as we know this is a key reason why people choose to continue working with us.

We have, however, seen a statistically significant lower performance in staff engagement, staff morale, we are safe and healthy and we are recognised and rewarded. The pressure our people feel at work is an area of concern as many have told us they do not feel there are not enough people available to do their job well.

#### Future priorities

The people element of our regain and renew plan (our people promise) seeks to respond directly to the feedback from the survey by identifying two clear priorities:

- We will make our people lives easier and free up time to work in a safe and calm way on agreed priorities. We will seek to do this by improving our workforce processes, such as reducing the time it takes to hire new people and rolling out e-rostering across our services. We will develop our approach to long term workforce planning and the development of career pathways so that we can grow our own future workforce – recognising the immense skills and talents of our people. We will continue our focus on retention and improving those areas that are most important to our people.
- We will also define and deliver a consistent, compassionate and inclusive leadership and management approach - ensuring that our managers and leaders feel valued and supported, have reasonable spans of control so workload is manageable, as well as the skills and confidence to lead effectively in these very challenging times.

Performance against our people plan is monitored through our People and Education Governance Group and ultimately the People Committee as a sub- committee of our Board of Directors.

## Diversity and inclusion

Diversity and Inclusion is at the forefront of everything we do within the NHS. We are committed to building an organisation that puts people's wishes at the centre and removing the barriers that hinder staff and prevent them working to their full potential.

Our values are the NHS values and we embed these through our recruitment and appraisal processes.. In addition, our people promise leadslead the way in which we treat all people whether a member of staff or the public. Our people can be assured that they will continue to be supported and valued to carry out their duties effectively, ensuring that everyone counts.

Our equality, diversity and inclusion programme of work is integral to the delivery of our people promise and is key to improving the experience of our people who are part of under-represented groups.

We developed our priorities for the programme through in-depth engagement with our people. These include:

- a relentless focus on addressing bullying and harassment through:
- raising the profile of unacceptable behaviour and addressing by holding people to account, providing support and further development for staff
- training managers to be confident in ~~addressingaddress~~addressing poor behaviours through our new leadership and management training package
- raising cultural awareness through education, personal reflection and modernised, meaningful mandatory training for all staff
- developing career pathways and supporting career progression has been predominantly focused on BME staff during this year. We recognise through our staff survey this needs to other groups of under-represented staff in particular those with a long-term condition or disability. A scheme of actions are being developed.
- strengthening and developing our networks to be even more influential and driving change for under-represented people remains to be a priority for 2023/24.

## Workforce Disability Equality Standards (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

## Making a difference for disabled staff

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Nine of the 13 WDES indicators are taken from the National Staff Survey. The table below shows our performance against the WDES standards and the actions taken in 2022/23 to address the position. Regrettably, despite the action taken the feedback

indicates an overall decline in experience for our people with a long-term condition (LTC), in comparison to our people without LTC that remains largely unchanged. The only indicators that are showing a degree of improvement are equal opportunities for career progression, reporting of bullying, harassment and aggression (BHA) and the marginal reduction in BHA from patient and service users

| | LTC or illness 2021 | Without LTC 2021 | LTC or illness 2022 | Without LTC 2022 | LTC or illness average 2022 |
|---|---|---|---|---|---|
| % staff experiencing BHA from patients, relatives or public | 32.1% | 25.4% | 31.9% | 25.3% | 32.4% |
| % staff experiencing BHA from manager | 16.3% | 8.7% | 18.7% | 8.6% | 17.1% |
| % staff experiencing BHA from colleagues | 24.5% | 15.9% | 29.2% | 15.7% | 26.9% |
| % of staff that reported experience of BHA | 48% | 48.6% | 49.8% | 48.4% | 48.4% |
| % staff believing equal opportunities for career progression | 49.7% | 59% | 50.8% | 58.8% | 51.4% |
| % staff feeling pressure from manager to come to work despite feeling unwell | 25.1% | 19.8% | 29.8% | 19.9% | 32.2% |
| % staff satisfied with the extent we value their work | 34% | 40.8% | 31.1% | 41.6% | 32.5% |
| % staff saying we have made adequate adjustments for them to carry out work | 76.3% | | 71.8% | | |
| Staff engagement score (0-10) | 6.4 | 6.9 | 6.3 | 6.8 | 6.4 |

## Actions undertaken in 2022/23

- anti-bullying advisors network available to provide a safe space and support for staff. A review and evaluation of this service has commenced to improve uptake, visibility and diversity of group
- reasonable adjustment information refreshed, promoted through health and wellbeing and employee relations team and continues to be available on the EDI web pages
- a team of mediators are available and have commenced promotion of their service and developing a stronger partnership.

To further address and see improvement in 2023/24 these are the actions that will be taken:

- following review and evaluation of anti-bullying advisor service co-design the programme of work to reduce BHA with members of EDI networks
- commencement of a programme of work focusing on a ‘Just and Learning Culture’. This will be designed to move our focus and practice of looking back at the harm done and the often-punitive consequences to one that seeks to understand what has happened focusing on the future and the trust that needs to be repaired and investment in relationships
- proactive focus on bullying and harassment to include raising awareness of incivility, personal attitude and behaviour impact on others
- further raising awareness of mediation network to provide proactive support and early intervention with managers. Training will be provided for managers through

the new leadership and management training package

- understanding barriers to career progression for people through our Disability Network and staff workshops
- renewed focus on our Disability Network to increase membership and diversity of people living with LTC
- recruit disability inclusivity representatives to be part in interview panels ensuring inclusive recruitment practices
- raise awareness of reasonable adjustment options and embed practice through task and finish group.

## Workforce Race Equality System

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations.

The WRES was introduced in 2015 to hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between our black and minority ethnic (BME) and white staff.

Four of the nine WRES indicators are taken from the National Staff Survey and these are the actions

The table below shows our performance against the WRES standard for the last two years and in comparison, to the national average. The broad headlines are: experience of bullying, harassment and abuse (BHA) from patients has remained consistent for white staff but has increased by over 3% for our BME staff which is significantly higher than the national average and must be an area of focus this ~~yearworryingly~~year worryingly, BHA from staff toward our BME staff has increased by over 7%, whilst remaining consistent for white staff. Again, this is significantly higher than the national average and must be an area of focus this year the percentage of staff feeling there are equal opportunities for career progression has remained largely consistent for both demographic groups and significantly higher than the national ~~averagethe~~average the prevalence of discrimination has also increased at a higher rate for our BME staff which is now above the national average and widens the disparity gap further. Engagement work to understand the nature and form discrimination is planned to ensure appropriate actions are developed~~,~~ but will be central to the redevelopment of our training and education around compassion and inclusion incorporating how we lead inclusively, and civility and respect.

| | BME 2021 | White 2021 | BME 2022 | White 2022 | BME Average 2022 |
|---|---|---|---|---|---|
| % staff experiencing BHA from patients, relatives or public | 33% | 26.5% | 36.2% | 26.4% | 30.8% |
| % staff experiencing BHA from staff | 24.6% | 22.3% | 31.8% | 22.9% | 28.8% |
| % staff believing equal opportunities for career progression | 51% | 57.3% | 51.7% | 57.1% | 47% |
| % staff experiencing discrimination at work | 17.3% | 6.3% | 18.6% | 6.9% | 17.3% |

| from manager or colleagues | | | |
|---|---|---|---|

The actions undertaken during 2022/23 to improve the experience of our BME staff included:

- in partnership with the clinical safety team we have reviewed the policies, guidance, systems and processes that address the rise in racist behaviour and language. This has included focused support for members of staff after such an incident
- we launched our inaugural BME Leadership programme where 29 BME members of staff completed and graduated. This was designed to increase personal and collective confidence in order to enable individuals to realise and reach their potential as inclusive leaders
- we have continued to support our BME network and staff to send out key messages within the organisation
- in collaboration with international staff designed a training package for managers to support the improvement of the integration and transition into the workplace for new international team members
- our EDI Lead, also the system BME network chair presented to the Integrated Care Board, sharing the experiences of international nurses as they integrate into their new workplace. The purpose being to improve their experience now and for future international nurses coming to Devon.

Despite these actions there is still further improvement to be made during 2023/24 and these include:

- commencement of a programme of work focusing on a ‘Just and Learning Culture’. This will be designed to move our focus and practice of looking back at the harm done and the often punitive consequences to one that seeks to understand what has happened focusing on the future and the trust that needs to be repaired and investment in relationships
- engagement with staff networks and wider forums to understand the nature and forms of bullying, harassment and discrimination. The findings will inform the development included in our training package for managers and wider organisation relating to compassion
- following review and evaluation of anti-bullying advisor service co-design the programme of work to reduce BHA. This will be done in collaboration with our EDI networks and will be informed by the point above
- commit with deliberate intent to an organisationalanti-racism charter that sets out a zero-tolerance position together with a campaign of raising awareness of unacceptable behaviours and support to educate and develop people when this occurs
- complete and launch of modernised mandatory training deigned to cause staff to reflect on their own behaviours and language towards others
- supporting career progression with the launch of a second BME Leadership programme.

### Actions undertaken

- vlogs were delivered by our Chief Executive at the beginning, during and end of Ramadan
- our BME EDI Lead is a vaccine ambassador and was interviewed by a local TV broadcaster to encourage the uptake of the vaccine

- we have worked alongside our international ~~nurse's~~nurses' team, to improve the experience of our BME nurses and to monitor their journey within the organisation
- a bullying and harassment project has been advertised and the training of advisors has taken place
- our Board of Directors participated in a facilitated development session discussing equality, diversity and inclusion and what this means strategically and their leadership role for the organisation.

### Next steps

- continue to grow our BME network to provide a safe space for our people's voices to be heard, to share experiences, offer peer support and have a sense of belonging
- ensure we have a rolling programme of events and spaces to increase confidence and trust of our staff. Encourage our BME staff to lead and take part in celebrating diversity and inclusion across the organisation
- implement listening events to hear the first-hand the experiences of our staff. Workshops are underway to gain insight and better understand barriers to career progression. Encourage members to share their stories safely.
- continue working with our communities to reach those we seldom hear from
- launch our managers essential training programme to raise awareness of bullying and harassment experiences, unconscious bias and the need for managers to be culturally competent and compassionate leadership training for managers to help support themselves and staff
- progress work to create an inclusive culture throughout the organisation through promoting self-awareness and ensuring recruitment processes are diverse and inclusive
- review our recruitment processes to support the recruitment of an inclusive and diverse workforce
- develop a range of resources for leaders and staff to engage in meaningful conversations around race and inequality
- address the lack of BME staff in Band 8A and above posts. Introduce Inclusivity reps on interview panels. Explore bespoke recruitment agencies and target recruitment and retention
- recruit members of BME staff to our Anti-Bullying Network. Campaign to encourage BME staff to join with support of the BME Network chair and the executives
- embark on a reciprocal mentoring programme with an emphasis on race
- promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, identifying any specific gaps requiring some targeted or bespoke programmes
- Continue to offer bespoke coaching programme for BME staff as part of our development offer
- modernise the EDI mandatory training for all staff raising awareness and educating everyone on EDI matters and personal impact on others.

## Gender pay differential

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The data in this report is based on snapshot taken on 31 March 2022.

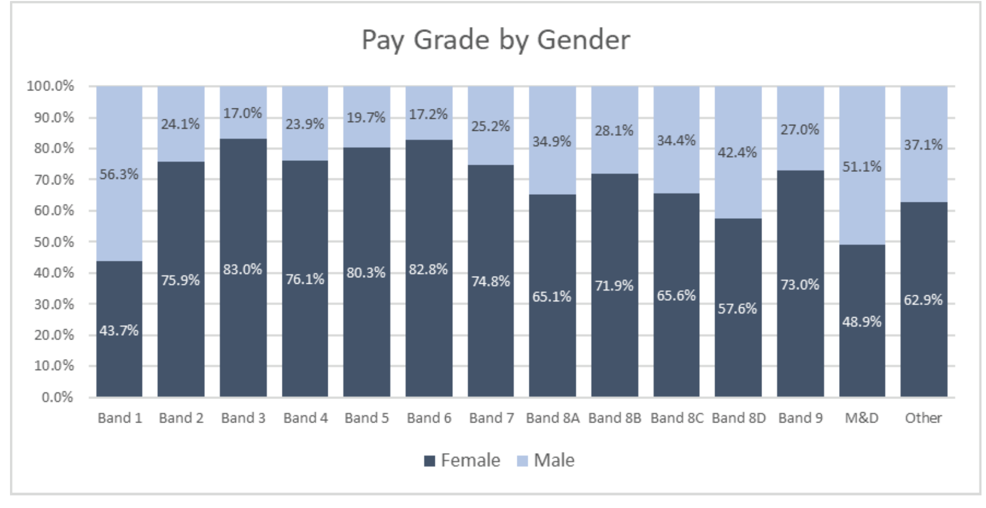
An analysis of the Foundation Trust workforce as at 31 March 2022, split by directors, Band 8A and above and all employees, is shown below:

| | Male % | Male headcount | Female % | Female headcount |
|---|---|---|---|---|
| Executive Directors | 57.1% | 4 | 42.9% | 3 |
| Band 8A and above | 31.0% | 95 | 69.0% | 211 |
| Employees | 21.83% | 1659 | 78.17% | 5940 |

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap analysis below shows the difference in the average pay between all men and women in a workforce. Generally, the average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. While a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower.

The current gender split within the overall workforce is 78.17% female and 21.83% male. The breakdown of proportion of females and males in each banding is as follows:



## Average gender pay gap

### Average gender pay gap as mean average (All applicable Foundation Trust staff)

| | Male | Female | % difference |
|---|---|---|---|
| **Mean hourly rate 2018** | £18.76 | £14.85 | 20.84% |
| **Mean hourly rate 2019** | £18.89 | £15.22 | 19.44% |
| **Mean hourly rate 2020** | £19.51 | £15.72 | 19.41% |
| **Mean hourly rate 2021** | £19.58 | £16.07 | 17.89% |
| **Mean hourly rate 2022** | **£20.62** | **£16.79** | **18.54%** |

### Average gender pay gap as median average (all applicable Foundation Trust staff)

| | Male | Female | % difference |
|---|---|---|---|
| **Median hourly rate 2018** | £14.16 | £13.10 | 7.49% |
| **Median hourly rate 2019** | £14.21 | £13.29 | 6.49% |
| **Median Hourly rate 2020** | £14.73 | £13.83 | 6.09% |
| **Median Hourly rate 2021** | £14.58 | £14.02 | 3.83% |
| **Median Hourly rate 2022** | **£16.12** | **£14.92** | **7.43%** |

### Summary of results average gender pay gap

The overall percentage variance for the average hourly rate of pay as a mean average is low at 18.54% and this has increased from last year which was 17.89%. This calculation is based on the average hourly rate of 5940 female staff compared to 1659 male staff; because the average is calculated over different numbers of staff (there are almost four times more female staff), some variance is to be expected.

The percentage variance for the median hourly rate of pay is 7.43%. This calculation is based on the average hourly rate at the mid-point for each gender group. This can be more indicative than the average hourly rate of pay as it is not impacted much by the female to male ratio.

However further investigation has shown that when medical and dental staff are removed from the calculations then the gender pay gap is in favour of female staff. It is the inclusion of our consultant body which shows to have a significant impact on the figures, as the majority of our senior consultants are predominantly male (148 male to 104 female consultants) and have a significant number of years seniority.

This impact can be seen on the mean hourly rate supporting the theory that medical and dental staff do influence the hourly rate which has risen to 13.04% after a 3-year reduction trend from 2019-2021. Male medical and dental staff have seen a 4% rise in their mean hourly rate in comparison to females who have seen a 3% average rise. This is comparable with the agenda for change staff who show male colleagues increase at 6% with their female colleagues at 5%. This can be related to the 60/40 split in male to female ratio for consultants.

- Having reviewed the data there are two themes which stand out: when looking at the total workforce, male staff are disproportionately represented in the lowest and highest pay quartiles
- the most obvious imbalance of pay is among the medical and dental staff, namely with regards to the historic CEA Bonus pay.

It is the inclusion of our consultant body which shows a significant impact on the figures, reversing the female positive gender pay gap across the remainder of our workforce.

Analysis of our medical workforce continues to reveal its own complexities. The junior doctors show a pay gap in favour of female staff, but at more senior level then this is in favour of male employees, with a higher number of male consultants employed compared to female. The legacy of a predominantly male consultant body is slowly changing, as demonstrated by the current junior doctor workforce, which shows a higher number of female employees compared to male.

Additional information on our latest published Gender Pay Gap Report can be found on the website at Equality and Diversity - Torbay and South Devon NHS Foundation Trust and at the Cabinet Office website at Torbay And Southern Devon Health And Care NHS Trust gender pay gap data for 2020-21 reporting year - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)

### Relevant union officials

| | |
|---|---|
| Number of employees who were relevant union officials during the relevant period | 1 |
| Full-time equivalent employee number | 1 |

### Percentage of time spent on facility time

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1 – 50% | 0 |
| 51% - 99% | 0 |
| 100% | 1 |

### Percentage of pay bill spent on facility time

| | |
|---|---|
| Total cost of facility time | £67.617.19 |
| Total pay costs | £303,439,016.38 |
| Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time divided by total pay bill) x 100 | 0.022% |

### Paid trade union activities

| | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on trade union activities by relevant union officials during the relevant period + total paid facility time hours) x 100 | 100.00% |

### Consultancy costs

Expenditure on consultancy costs for 2022/23 was £936,000 compared with £362,000 for 2021/22.

### Off-payroll report

PES (2018)13 requires the Foundation Trust to seek assurance from individuals working through off-payroll engagements, that all their tax obligations are being met. This is required for existing and new engagements that during the period between 1 April 2022 and 31 March 2023 cost more than £245 per day and were engaged for more than six months.

The Foundation Trust is required under the reporting requirements published by HM Treasury in relation to PES (2018)13, to report if it had any engagements which met the disclosure requirements. The Foundation Trust can confirm that it had no engagements requiring disclosure.

## Off-payroll worker engagements as at 31 March 2023

| **Number of existing engagements as of 31 March 2023** | 4 |
|---|---|
| Of which………. | |
| Number that have existed for less than one year at time of reporting | 0 |
| Number that have existed for between one and two years at time of reporting | 0 |
| Number that have existed for between two years and three years at time of reporting | 2 |
| Number that have existed for between three and four years at time of reporting | 0 |
| Number that have existed for four or more years at time of reporting | 2 |

## All off-payroll workers engaged at any point during the year ended 31 March 2023

| **Number of off-payroll workers engaged during the year ended 31 March 2023** | 5 |
|---|---|
| Of which………. | |
| Number assessed as within the scope of IR35 | 0 |
| Number assessed as not within the scope of IR35 | 5 |
| Number of engagements reassessed for consistency/assurance purposes during the year | 1 |
| Of which: Number of engagements that saw a change to IR35 status following review | 0 |

## For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023

| Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year | 0 |
|---|---|
| Number of individuals that have been deemed ‘Board members and/or senior officials with significant responsibility’ during the financial year. This figure must include both off-payroll and on- payroll engagements | 20 |

Note: The Foundation Trust has a number of doctors who meet the financial criteria but have no significant financial responsibility and therefore fall outside of the scope of the reporting requirement.

## **Staff exit packages paid in year (audited information)**

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

| Exit package cost band (including any special payment element) | Compulsory redundancies | | Other departures agreed | | Total of exit packages | | Departures where special payments have been made | Special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | Number | Cost £'000 | Number | Cost £'000 | Number | Cost £'000 | Number | Cost £s |
| **Less than £10,000** | - | - | 18 | 68 | **18** | **68** | 1 | 4 |
| **£10,001 - £25,000** | - | - | 5 | 68 | **5** | **68** | - | - |
| **£25,001 - 50,000** | - | - | 2 | 61 | **2** | **61** | - | - |
| **£50,001 - £100,000** | - | - | - | - | **-** | **-** | - | - |
| **£100,001 - £150,000** | - | - | - | - | **-** | **-** | - | - |
| **£150,001 - £200,000** | - | - | - | - | **-** | **-** | - | - |
| **Greater than £200,000** | - | - | - | - | **-** | **-** | - | - |
| **Total number of exit packages by type** | **-** | **-** | **25** | **197** | **25** | **197** | **1** | **4** |

Redundancy and other departure costs have been paid in accordance with the provisions of the national Agenda for Change scheme where payment has been made in lieu of notice, or the locally agreed MARS scheme which is based on national guidance. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

~~Exit packages: other (non-compulsory) departure payments (audited information)~~

Exit packages: other (non-compulsory) departure payments (audited information)

| | 2022/23 | | 2021/22 | |
|---|---|---|---|---|
| | **Agreements Number** | **Total Value of Agreements £000** | **Payments agreed Number** | **Total value of agreements £000** |
| Voluntary redundancies including early retirement contractual costs | 1 | 34 | - | - |
| Mutually agreed resignations (MARS) contractual costs | 1 | 27 | 18 | 719 |
| Early retirements in the efficiency of the service contractual costs | - | - | - | - |
| Contractual payments in lieu of notice * | 22 | 132 | 19 | 108 |
| Exit payments following Employment Tribunals or court orders | - | - | | - |
| Non-contractual payments requiring HMT approval ** | 1 | 4 | - | - |
| **Total** | **25** | **197** | **37** | **827** |

*any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice.

## Apprenticeships

Apprenticeships continue to be an ideal way for anyone to earn a wage while gaining a valuable qualification.

Hiring apprentices helps all businesses and organisations employ local talented people and supporting career aspirations, benefitting the organisation, the person and the local community. Apprentices provide organisations such as the NHS with a motivated, talented, skilled and qualified workforce.

Being an apprentice provides opportunities to gain a nationally recognised qualification, develop professional skills, while earning a salary.

we currently employ almost 300 apprentices in many clinical, allied healthcare and business roles. The number of apprentice employees increases annually.

Since 2017 we have supported over 500 apprentices through their apprenticeship and into successful working roles. Some of our apprentices go on to achieve a BSc degree in their chosen career. This includes nurses, occupational therapists, physiotherapists, radiographers, healthcare science practitioners in cardiology, Respiratory and engineering, managers and senior leaders etc.

All apprenticeship training programmes are paid for by the employer organisation, and enable those who may not be in a position to take on a student loan to achieve their career aspirations from a level 2 apprenticeship up to and beyond a BSc apprenticeship.

As the largest employer in the region, we truly value our people and use the resources available to us for the benefit of the employee and ensure that nobody is excluded, discriminated against, or left behind.

We are an inclusive organisation and we continue to support as many people as possible into our organisation. Apprenticeship opportunities provide another respected route into our organisation as well as supporting the career aspirations of those who currently work with us.

This concludes the Staff Report for 2022/2023.

Liz Davenport, Chief Executive 28 June 2023

## PART V – GOVERNANCE STATEMENTS

### Statement of the Chief Executive's responsibilities as the Accounting Officer of Torbay and South Devon NHS Foundation Trust:

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Torbay and South Devon NHS Foundation Trust NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Torbay and South Devon NHS Foundation Trust NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust’s performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust’s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity’s auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Liz Davenport, Chief Executive
28 June 2023

## Our Governance

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards. While doing this, the Board:

- monthly in order to discharge its duties effectively
- systems and processes are maintained to measure and monitor the organisations effectiveness, efficiency and economy as well as the quality, of its healthcare delivery
- reviews performance against regulatory and contractual obligations, approved plans and objectives. Metrics, measures and accountabilities have been developed to assess progress and delivery of performance
- all directors are encouraged to constructively challenge each other and the Executive, whilst maintaining and acknowledging their collective responsibility
- Non-Executive Directors scrutinise the performance of the Executive Directors in meeting agreed goals and objectives and monitor the reporting of performance. If a Board member disagrees with a course of action it is minuted accordingly. The Chairman would then hold a meeting with the Non- Executive Directors. If the concerns cannot be resolved this should be noted in the Board minutes
- Non-Executive Directors are appointed for a term of three years by the Council of Governors. The Council of Governors has the authority to appoint or remove the Chairman or the Non-Executive Directors at a general meeting. Removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors
- Non-Executive Directors are determined by the Board to be independent
- no voting Board or Council of Governor member holds a Director or Governor position within any other NHS Foundation Trust
- operates a code of conduct that builds on our organisational values to reflect high standards of probity and responsibility
- in discussion with the Council of Governors a Non-Executive Director covers the role of Senior Independent Director
- the Chairman ensures that the Board of Directors and the Council of Governors work together effectively and that directors and governors receive timely and clear information that is appropriate to carry out their duties
- the Chairman holds regular meetings with Non-Executive Directors without the Executive Directors present
- no independent external adviser has been a member of or had a vote on the Committees responsible for the appointments or remuneration of Executive or Non-Executive Directors
- the Committee responsible for setting levels of remuneration for Executive Directors has delegated authority from the Board to do so
- independent professional advice is accessible to the Non-Executive Directors and the Trust Secretary via the appointed independent external auditors and/or via external legal firms
- there is no full-time Executive Director that takes on more than one Non-executive Director role of another NHS Foundation Trust or another organisation of comparable size and complexity
- all Board meetings and Board Committee meetings receive sufficient resources and support to undertake their duties
- a going concern report is undertaken annually

- effective mechanisms are in place to ensure co-operation with relevant third-party bodies
- in accordance with the Code, our organisation is led by the Board of Directors who have joint and several responsibilities for the exercise of the powers of the Foundation Trust. Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted. The Board does not consider that its performance or balance was significantly impacted during any period of interim arrangements.

The Council of Governors:

- represents the interests of the organisation's members and partner organisations in the local health economy.
- has a code of conduct in place to ensure Governors adhere to our best interests and values
- holds the Board of Directors to account for our performance and receives appropriate information on a regular basis
- governors are consulted on the development of our forward plans and arrangements are in place for them to be consulted on any significant changes to the delivery of our business plan if so required
- the Council of Governors meet on a regular basis in order for them to discharge their duties
- the governors elect a lead governor. As lead governor, the main function is to act as a point of contact with NHSE, the directors and governors continually update their skills, knowledge and familiarity with our organisation and our obligations, to fulfil their role on various Boards and Committees
- our constitution is available on the website and outlines the clear policy and fair process for the removal from the Council of Governors of any governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties
- the performance review process of the Chairman and Non-Executive Directors involves the governors, is conducted by the Senior Independent Director and in accordance with NHSE guidance. Each Executive Director's performance is reviewed by the Chief Executive. The Chairman reviews the performance of the Chief Executive
- the Committee responsible for setting remuneration of Non-Executive Directors and the Chairman adhere to the NHSE guidance when reviewing levels of remuneration
- the Committee responsible for the appointment of Non-Executive Directors comprises a majority of governors
- the Chief Executive ensures that the Board of Directors and the Council of Governors act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman contemplates a course of action involving a transaction which the Chief Executive considers infringes these requirements, the procedures set by NHSE for advising the Board and Council for recording and submitting objections to decisions will be followed. During 2022/23 there have been no occasions on which it has been necessary to apply the NHSE procedure
- our staff are required to act in accordance with NHS standards and accepted standards of behaviour in public life (Nolan Principles).

- We ensure compliance with the Fit and Proper Person (FPP) requirement for the Board of Directors. All existing Directors completed a self- declaration. All new appointments are also required to complete the self- declaration and the full requirements of the FPP test have been integrated into the pre-employment checking process.

## Statement of compliance with the NHS Foundation Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance, as published and applicate for this financial year, on a ‘comply or explain’ basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, originally issued in 2012. It is noted that a new code of governance has been published for NHS providers for year ending 31 March 2024, this will be reflected in next years' accounts and adhered to within the year commencing 1 April 2023.

NHS Foundation Trusts are required to provide a specific set of disclosures in the annual report to meet the requirements of the Code of Governance.

Information relating to governance systems and processes is detailed in the Annual Report, and in particular the Annual Governance Statement. Details of the Constitution of the Board are given in the Accountability Report.

## Mandatory disclosures

| ***Relating to*** | ***Code provision*** | ***Summary of requirement*** | ***Location in Annual Report*** |
|---|---|---|---|
| Board and Council of Governors | A.1.1 | The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved.<br>The annual report should also include this schedule of matters or a summary statement of how the board of directors operate, including a summary of the types of decisions to be taken by the board and council which are delegated to the executive management of the board of directors. | Accountability Report Pages xxx<br><br>Governance Statements – Page xxx |
| Board, Audit Committee, Nominations and Remuneration Committee(s) | A.1.2 | The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees.<br>It should also set out the number of meetings of the board and those committees and individual attendance by directors. | Accountability Report Pages xxx |
| Council of Governors | A.5.3 | The annual report should identify the members of the council of governors, including the description of the constituency or organisation they represent whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the lead governor. | Accountability Report Pages xxx |
| Council of Governors | FT ARM* | The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors. | Accountability Report Page xxx |

| | | | |
|---|---|---|---|
| Board | B.1.1 | The board of directors should identify in the annual report each of the non- executive director it considers to be independent, with reasons where necessary. | Accountability Report Page xxx |
| Board | B.1.4 | The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Foundation Trust. | Accountability Report Page 46 and Appendix A - Pages xxx |
| Board | FT ARM* | The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated. | Remuneration Report Pages xxx |
| Nomination and Remuneration Committee(s) | B.2.10 | A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. | Accountability Report Page xx |
| Nomination and Remuneration Committee(s) | FT ARM* | The disclosure in the annual report on the work of the nomination committee(s) should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non- executive director. | Not applicable |
| | | A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report.Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. | No other significant commitments to report |
| Council of Governors | B.5.6 | Governors should canvass opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | Accountability Report Pages xxx |
| Council of Governors | FT ARM* | If during the financial year, the governors have exercised their power under paragraph 10C of Schedule 7 of the NHS Act 2006, to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties, then information on this must be included in the annual report. | Not applicable |
| Board | B.6.1 | The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. | Accountability report Page xx |
| Board | B.6.2 | Where there has been an external evaluation of the board and/or governance of the Foundation Trust, the external facilitator should be identified in the annual report and statement made as to whether they have any other connection to the Foundation Trust. | Not applicable for the reporting period |
| Board | C.1.1 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are | Accountability Report Page xx |

| | | | |
|---|---|---|---|
| | | fair, balanced and understandable and provide information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). | Annual Governance Statement page xx |
| Board | C.2.1 | The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. | Governance Statements Pages xx |
| Audit Committee/ control environment | C.2.2 | A Foundation Trust should disclose in the annual report:<br>if it has an internal audit function, how the function is structured and what role it performs; or<br>if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. | Accountability Report Pages xx |
| Audit Committee/ control environment | C.3.5 | If the council of governors does not accept the audit committee's recommendation on the appointment, re-appointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. | Not applicable |
| Audit Committee | C.3.9 | A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include:<br>the significant issues that the committee considered in relation to financial statements, operations and compliance, and how those issues were addressed;<br>an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length or tenure of the current audit firm and when a tender was last conducted; and<br>if the external auditor provided non- audit services, the value of the<br>non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. | Accountability Report Pages xxx |
| Board, Nomination and Remuneration Committee | D.1.3 | Where an NHS Foundation Trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. | Not applicable |
| Membership | E.1.4 | Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report. | Appendix B Pages xxx |
| Board | E.1.5 | The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at | Accountability Report Pages xx |

| | | | |
|---|---|---|---|
| | | meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. | |
| Board/ Membership | E.1.6 | The board of directors should monitor how representative the NHS Foundation Trust's membership is and how the level and effectiveness of member engagement and report this in the annual report. | Accountability Report Page xx |
| Membership | FT ARM* | The annual report should include:<br>a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;<br>information on the number of members and the number of members in each constituency; and<br>a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members. | Accountability Report Pages xxx |
| Board/Council of Governors | FT ARM* | The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. | Accountability Report Pages xxx |
| *FT ARM disclosures are required by the NHS Foundation Trust Annual Reporting Manual rather than the NHS Foundation Trust Code of Governance. | | | |

## Comply or explain disclosures

NHS Foundation Trusts are required to provide a specific set of disclosures in relation to the provisions within Schedule A of the NHS Code of Governance. We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis and has complied with the Code during 2022/23, except for the following:

| | |
|---|---|
| A3.1 | The Chairman has been reappointed for further one-year term of office, being his tenth year in post. This re-appointment was made in accordance with the direction of NHS England to ensure consistent strategic leadership due to the Devon systems status within SOF4. Due consideration was given to the perception of independence of the postholder when extending the term of office and the balance of risk. |
| B.1.2 | During the year there was a period where there was an equilibrium of Non-Executive Directors (NEDs) and Executive Directors (EDs), as opposed to a positive balance of NEDs. This arose due to an unexpected NED departure and was managed promptly through the recruitment and appointment of two new NEDs in August and September 2022. |

## ~~ANNUAL GOVERNANCE STATEMENT~~

## **Annual Governance Statement**

### Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that our organisation is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

### The purpose of the system of internal control

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Torbay and South Devon NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

### Capacity to handle risk

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the organisation and these meet all statutory requirements and adhere to guidance issued by NHS England in respect of governance and risk management.

We have a risk management strategy, which is reviewed and endorsed by the Board of Directors. The strategy provides the framework for managing risks across the organisation which is consistent with best practice and Department of Health and Social Care guidance. The strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of sub-committees that scrutinise and review assurances on internal control. These include the Audit and Risk Committee, Quality Assurance Committee, People Committee and the Finance, Performance and Digital Committee. Underpinning these sub-committees are the Executive-led groups – including the quality improvement group, risk group and other groups managing the operational delivery of information management and technology, estates and people.

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality Assurance Committee. The Board of Directors receives a report from the Chair of each of the Board sub-committees. The Board of Directors also receives the Board assurance framework and corporate risk register at each meeting.

The risk group oversees all risk management activities across the organisation to ensure that the correct strategy is adopted for managing risk, controls are present and effective, action plans are robust for these risks that are being actively managed and that high risks are scored appropriately. The risk group is chaired by the Chief Finance Officer. Membership comprises all Executive and Associate Directors; other standing attendees include the Director of Health Informatics, Director of Corporate Governance, Corporate Governance Manager and the Risk Officer. In addition, the Executive Directors have in place a process whereby all significant risks to the achievement of service delivery unit and directorate objectives, NHS England governance and compliance requirements and Care Quality Commission regulations are kept under review.

Established governance arrangements maintain effective risk management arrangements across the Integrated Service Units (ISUs) maintain risk registers and report accordingly. The system directors for each of the ISUs are responsible and accountable to the Chief Operating Officer for the quality of the services they manage and to ensure that any identified risks are placed on the ISU risk register. All such risks are reviewed by the relevant ISU and any escalation as required is managed in accordance with the risk reporting process. It should be noted that the ISU structure will change in the year ended 31 March 2024 following a clinical governance review.

While the Chief Executive has overall responsibility for the management of risk, other members of the Executive team exercise lead responsibility for the specific types of risk as follows:

| | |
|---|---|
| Strategic risk | Chief Executive |
| Clinical and quality risks | Chief Nurse/Medical Director |
| Financial risks | Chief Finance Officer |
| Workforce risks | Chief People Officer |
| Clinical staffing risks | Chief Nurse/Medical Director |
| Operational risks | Chief Operating Officer |
| Information management and technology risks | Director of Transformation and Partnerships |

All Board level directors are responsible for ensuring there are appropriate arrangements and systems in place to identify and assess risks and hazards, comply with internal policies and procedures, and statutory and external requirements and integrate functional risk management systems and develop the assurance framework. These responsibilities are supported operationally by service unit managers.

All members of staff have responsibility for participation in the risk/patient safety management system, through:

- awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments
- compliance with all legislation relevant to their role, including information governance requirements set locally by the organisation
- following all our policies and procedures
- reporting all adverse incidents and near misses via our incident reporting system
- attending regular training as required ensuring safe working practices
- awareness of our patient safety and risk management strategy
- knowing their limitations and seeking advice and assistance in a timely manner when relevant.

We recognise the importance of supporting staff. ISU and directorate risk management activities are supported by a risk management training programme, principally delivered by the risk officer,. Executive Directors and Non-Executive Directors are provided with risk management development on an individual basis or collectively at Board seminars.

We continue to maximise our opportunities to learn from other Foundation Trusts (particularly those who achieve outstanding CQC ratings), internal/external audit and continuous feedback is sought internally to ensure the systems and processes in place are fit for purpose. The findings are taken to the relevant Executive lead and/or Committee to ensure that any learning points are implemented. A wider distribution of learning points for staff is disseminated via staff briefings and bulletins.

In addition to the organisation reviewing all internally driven reports, we adopt an open approach to the learning derived from third party investigations and audits, and/or external reports. We have also adopted a pro-active approach to seeking independent reviews should concerns be raised of a significant magnitude.

I have ensured that all risks of which I have become aware are reported to the Board of Directors. All new significant risks are escalated to the Executive Lead and reviewed and validated by the risk group. There is a regular review of risks on the Board assurance framework by the Board of Directors as a collective Board and at Board Committee; the purpose of which is to scan the horizon for emergent threats and opportunities, and consider the nature and timing of the response required to ensure the risk is kept under control. Risk and assurance is also discussed annually at Board development days.

## The risk and control framework

Risk is managed at all levels of the organisation and is co-ordinated through an integrated governance framework consisting of a number of key groups that report on a regular basis to either the Quality Assurance Committee, People Committee, Finance, Performance and Digital Committee, Building a Better Future Committee or Audit and Risk Committee.

The key groups are: safeguarding / inclusion group, quality improvement group, serious adverse events group, people and education governance group, estate performance and compliance group, transformation and cost improvement programme group, finance delivery group, capital infrastructure and delivery group, information management and IT group, risk group, building a brighter future programme group and integrated governance group.

Our risk management strategy has defined our approach to risk throughout the year and provides an integrated framework for the identification and management of risks of all kinds, whether clinical, non-clinical, corporate, or financial and whether the impact is internal or external. This is supported by a Board assurance framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management. At each Board of Directors meeting, papers are provided with a report summary sheet through which directors identify links to one or more corporate objectives and one or more overarching corporate level risks / themes.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the risk management policy. Across a range of domains, the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. Our risk tolerance is defined as: 'the amount of risk the Foundation Trust is prepared to accept, tolerate or be exposed to at any point in time'.

In setting a tolerance, it has been determined that any risks to the delivery of the organisation's objectives with a current risk score of 15 or above will be brought through the exception reporting process via the Risk Group and Board Sub-Committees to the Board of Directors if deemed to be a corporate level risk. Actions and timescale for resolution are agreed and monitored. Such risks are deemed to be acceptable by the Executive Team only when there are adequate control mechanisms in place and a decision has been made that the risk has been managed as far as is reasonably practicable. Risks scored below this level are managed by the relevant lead director, service unit or directorate.

The Risk Group receives reports on any risks which could impact on our strategic objectives, particularly those risks deemed to be 'major' or 'catastrophic' or which could escalate to these levels if action is not taken. The Risk Group also oversees the development of our long-term strategy and implementation of the risk management and assurance framework. A deep dive schedule was established during the year which ensures that significant risks (current risk score of 15) receive detailed scrutiny at the Risk Group, Audit and Risk Committee, Quality Assurance Committee, People Committee, Building a Better Future Committee or Finance, Performance, and Digital Committee meetings. Further information can be found within our risk management policy.

Significant risks (any with a current risk score of 15 or more in accordance with the risk scoring matrix) will be reported to and considered by the Risk Group. If it is deemed that a risk is a ‘corporate level’ risk, it will be added to the corporate risk register as described in our risk management policy or linked to an existing Corporate Level Risk with a shared theme.

The Risk Group reviews the corporate risk register to ensure that:

- the risk has been appropriately assessed and recorded
- actions plans/points are in place and leads identified and timescales for delivery
- the risk and action points/plans are monitored to completion.

Risks posing a threat to our strategic objectives are escalated to the Board assurance framework.

The Executive Team is responsible for:

- ensuring that programme and operational risks are actively managed within their areas of the business
- being owner and action owner of individual risks (including those delegated by the Chief Executive)
- devising short, medium, and long-term strategies to tackle identified risk, including the production of any mitigating action plans.

The Audit and Risk Committee has responsibility for the review of governance, risk management and internal control covering both clinical and non-clinical areas. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management (including regular review of the Board assurance framework and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives. The Audit and Risk Committee will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Audit and Risk Committee may review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation and make recommendation to the Board of Directors where appropriate. Where the Audit Committee feels that there is evidence of ultra-vires transactions, evidence of improper acts or if there are other important matters that the Committee wishes to escalate, the Chair of the Audit and Risk Committee will raise these at a full meeting of the Board of Directors and, if appropriate, exceptionally to NHSE. After each meeting, the Chair of each Committee is required to provide a summary report to the Board of Directors addressing ‘key issues’ and any ‘key decisions/recommendations.

The Board of Directors evaluates the Board assurance framework at each meeting with any exceptions being reported at other times of the year. Corporate level risks / themes are included on all Board papers in relation to the action being taken to manage these risks.

An example of where risk management is incorporated into our core business is in relation to the integrated finance, performance, quality and people Board report. The monthly report to the Board of Directors provides commentary on performance and on key variances and improvements. The report is created by the outcomes and actions from various meetings, for example, the integrated governance group

meetings and Executive team weekly meetings. Each of the Board Sub-Committees also reviews the section appropriate to scope of their work at each of their meetings, for example the People Committee receive the people section of the integrated Board report.

We ensure that public stakeholders are involved in managing risks which impact on them. The Council of Governors, having responsibility for representing our members and the public, receive briefings from the Chief Executive and Chair and have regular dialogue with the Chair, Executive Directors and Non-Executive Directors.

Matters pertaining to our performance, both quality, financial and people-related, and any changes to our services are reported.

Discussions have also been ongoing throughout the year with commissioner colleagues to ensure all key access targets are being managed from within available resource. There have been regular contract management meetings with our lead commissioners and councils.

### Principal risks

Our risk management processes have identified a number of risks for 2022/23. These system-wide risks relating to unprecedented challenges as a consequence of the COVID-19 pandemic as well as achieving financial sustainability and controlling costs, while having sufficient monies to maintain the digital and estate infrastructure to ensure continued patient safety, quality and productivity have been considered and reflected in the Board assurance framework. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

The risks to the achievement of our strategic objectives are described in the Board assurance framework for 2022/23 as:

Board Assurance Framework (BAF)

*BAF Reference 1: quality and patient experience*
*Objective: to deliver high quality health and care services, achieving excellence in health and wellbeing for patients and local community*

- risk of not meeting pace and scale of change required to minimise harm and poor patient experience and meet System Oversight Framework 4 exit criteria
- risk of clinical leadership capacity inability to lead change
- ~~riskRisk~~risk of gaps in leadership capacity and capability across new care group structure
- risk of gaps in expertise and capacity within the quality and patient safety functions
- ~~riskRisk~~risk of capacity and capability inability to monitor /interrogate business/clinical Intelligence data
- risk of quality /governance systems across organisation and within the newly emerging care group structure not being able to mature quickly enough

*BAF Reference 2: people*
*Objective: to build a culture where our people feel safe, healthy and supported*

- risk in relation to turnover of leaders/managers against measures of vacancy controls
- risk of inadequate workforce capacity and resilience, burnout/fatigue arising from

ongoing significant operational pressures
- risk of lack of talent pipeline and supply, recruitment and retention of staff across specific specialties/professional groups, due to no strategic business or workforce planning
- risk of failure to fully implement our people promise – specifically leadership framework, management training and just and learning culture
- risk of unaffordable workforce costs due to increased use of bank and agency staff
- risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
- risk of inability to build a culture where people feel safe, healthy and supported due to rising number of EDI related grievances and a reported decline in workplace experience by those with disabilities or from a BAME background.

*BAF Reference 3: financial sustainability*
*Objective: to achieve financial sustainability and deliver the ICS three-year financial recovery plan, enabling appropriate investment in the delivery of outstanding care*

- inflation outstrips funding available resulting in a deterioration in financial performance
- digital and physical environments are not fit for purpose
- recruitment and retention are difficult for highly skilled clinical staff
- failure to comply with best practice guidance such as GIRFT and model hospital
- material differences between income and costs for specific services most notably adult social care
- capacity and capability of senior budget holders is variable
- gaps within the CIP programme
- ongoing challenges with data quality and information availability, driven by limited capability of digital systems and significant capacity issues in data warehousing
- GIRFT response, has been inconsistent, missing an opportunity to implement best practice
- impact of operational pressures on ability to deliver financial plans.
- reintroduction of activity-based payments on the horizon with limited in-house capacity to support
- productivity has not recovered to pre-Covid levels and recovery funding is often non-recurrent in nature

*BAF Reference 4: estates*
*Objective: to provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times*

- ~~theThe~~the estate is heavily dilapidated with £60m of backlog reported to NHSEI through the Estates Return Information Collection (ERIC) in 2022 (half is high and significant risk)
- insufficient engineering infrastructure capacity, capability and resilience to maintain activity and safe environments
- inability to improve and reconfigure the estate due to significantly aged infrastructure and insufficient funding impacting the delivery of clinical activity (e.g. lack of suitable clinical rooms to meet demand, insufficient office-accommodation to meet needs of all clinical and non-clinical teams)

- aging premises, requiring additional servicing and repair
- premises infrastructure and layout not efficient for modern healthcare needs.

*BAF Reference 5: operations and performance standards*
*Objective: 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*

- imbalance between time of emergency admissions and discharges
- insufficient capacity in care home and domiciliary care market
- continued infection outbreaks resulting in reduced bed capacity and ability to move patients to the right bed
- insufficient internal and externally sourced capacity to manage elective demand
- inadequate information and data analysis to respond to emerging threats
- low skill level of staff in managing non-elective and elective demand.

*BAF Reference 6: digital and cyber resilience*
*Objective: to provide clinical and administrative IT systems, and supporting digital infrastructure, that efficiently and cost-effectively meet our clinical models of care and key business needs, and support the confidentiality, integrity and availability requirements of a modern health and care provider delivering 24/7/365 services.*

- potential for increase of licensing costs above inflation
- shift to annual maintenance fees for licenses impacting on revenue
- systems unavailable due to ransomware attacks
- inability to refresh IT hardware before it ceases to perform or becomes unsupported
- poor data centre/data network storage environment resulting in outages
- requirement to update software with patches can result in system failure
- inability to reprocure/~~reprovide~~re-provide end of life systems affecting business continuity.

*BAF Reference 7: Building a Brighter Future (BBF)*
*Objective: 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*

- uncertainty in the national funding availability within the New Hospital Programme
- significant increase in inflationary pressures impact overall affordability of the preferred option within the strategic outline case.

*BAF Reference 8: transformation and partnerships*
*Objective: to implement our plans to transform services, using digital as an enabler, to meet the needs of our local population*

- significant challenges in quality, safety, performance and financial improvement will require a large-scale change programme to be ~~mobilized~~mobilised at pace
- ability to recruit the required level of expertise into the improvement and innovation team
- further requirement of improvement expertise within the ICS to deliver system-wide improvement programmes
- no standardised or co-ordinated approach to leading improvement programmes across the ICS
- basic IT and estate infrastructure is poor and does not enable significant levels of

transformation at pace.

*BAF Reference 9: Integrated Care System*
*Objective: to create the conditions for collaborative working and delivery of shared goals in partnership with the ICS*

- our partnerships across the ICS are critical in securing improvements in the delivery of services for local people.
- the sustainability of clinical services requires networking across the ICS and the capacity to deliver change at pace
- there is an urgent need to standardise back-office processes and functions to deliver the appropriate transformation.

*BAF Reference 10: green plan/environmental, social and governance*
*Objective: to deliver on our plans and commitments to environmental sustainability*

- infrastructure across the estate is aged and not environmentally efficient
- the existing infrastructure is aged to a point where assets cannot be easily added or replaced with environmentally efficient ones (due to the condition of the infrastructure on to which they would be attached)
- sufficient focus and priority is not given to the implementation of our green plan as resource availability is limited and focussed on operational delivery and recovery.

### Financial, performance, people and quality risks

As we go into 2023/24, we have developed a series of improvement plans which will support our progress against the NOF 4 exit requirements as agreed with the ICS and NHS England Regional team. Outcomes will be measured by a monthly review of financial, quality, performance and people information by the Board, in addition to scrutiny of the impact of efficiency savings on patient safety and quality of service.

The People Committee provides assurance on activity to deliver and measure the impact of our people promise.

A Board Sub-Committee focusing on finance and performance is in place to provide additional scrutiny of productivity and the delivery of recovery plans for planned and cancer care, urgent care and diagnostics. There is a regular programme of specialty reviews which review progress against operational efficiency opportunities as demonstrated by the Getting it Right First Time programme. Our plans, which reconcile local strategic priorities with the ICS Devon forward plan have been developed to ensure recovery of operational performance and make progress towards a three-year financial recovery programme for Devon.

We have implemented a senior management-led governance groups (including the Recovery Group) as part of our oversight of operational and financial delivery and progress against NOF 4 requirements.  This has been the vehicle through which efficiency programmes are planned, managed as well as supported by external partners. Cost improvement programme delivery does however remain a significant challenge as we move in to 2023/24, with changes to the NHS financial regime, ongoing high levels of inflation, and a difficult industrial relations climate.

### Capital funding risks

We reported a deficit in 2022/23 and have seen reduced levels of underlying EBITDA associated over a number of years. This has significantly restricted the level of cash available for capital expenditure. As a result, we are reliant on external funding through public dividend capital to fund a significant proportion of its capital programme, such as essential repairs and replacements across all areas of expenditure, estates, information management and technology and medical equipment. The ability to invest in developmental capital necessary to further develop our care model has similarly been curtailed.

Nevertheless, we have access to significant amounts of national funding which has mitigated to a large extent the shortfall in internally generated cash. We are further developing further sources of finance through ongoing negotiation with NHSEI that will enable this risk to be addressed, including: a strategic estates partnership, lease options, bidding, largely through ICS processes for public dividend capital and, where appropriate and subject to the necessary approvals, debt financing (loans).

### System cost pressures

The pressure in the 2022/23 cost base reflects increased pressure on health services in general, and the significant focus on elective, diagnostic and cancer recovery. We have also continued its targeted investment programme in safer staffing and has relied heavily on in-sourcing and out-sourcing of elective and diagnostic services to recover performance against national targets. We continue to depend on agency medical and nursing staff in a number of shortage areas. Uniquely, and most significantly in our organisation, are pressures building in continuing health care and adult social care. This is largely the result of a number of providers withdrawing from the market or experiencing financial difficulties driven by inflation and staffing pressures. As we look forward to 2023/24, sustained inflation will be a significant risk to market sustainability in the residential and nursing care sector.

The NHS Devon system-wide plans for 2023/24 have been developed in conjunction with our partners and through the Board. These have been subject to significant external support through a panel of professional advisors and scrutinised by the regulator. The Board has acknowledged that we must continue to develop our planning and delivery models, and to this end we are implementing a revised operational structure. An enhanced accountability framework and programme management office supports this model.

The financial outlook is challenging and there is significant risk to achieving the necessary level of financial improvement within our organisation and across the ICS for Devon. Our cost saving and efficiency programme in 2023/24 amounts to £46.1m, a quantum never previously achieved, which will demand significant service redesign at pace.

## Urgent and emergency care ~~To be reviewed for alignment with previous content]~~

We will continue our improvement towards achieving the National UEC standards in 2023-24 specifically the 4 Hour Access Standard and 15 min Ambulance Handover Standard. The Trust will be working closely with the Emergency Care Improvement Support Team (ECIST) and the Regional Team to ensure plans are in place to support these measures. Internally an Urgent and Emergency Care Board has been established to further focus the impact on improvement.

As an integrated Care Organisation there will be a continued focus on patients with "No Criteria to Reside" (NCTR). The Trust has performed well against this metric in 2022-23. Moving into 2023-24 the opening of the Jack Sears Units provides the opportunity to go further on this standard and supports the plan of achieving 5% NCTR. This would be regarded as best practice in the region and builds on the positive reputation the Trust has developed in relation to pathway management for these patients.

## Elective Waiting time for routine care

During 2023-24 the Trust will continue to pursue improvements in our waiting times in line with National priorities~~.~~, as noted in our Performance Analysis, pages xx. The target is to have all patients who are waiting longer than 65 weeks treated by 31st March 2024. The Trust has worked very closely with NHS England to develop robust plans to support these activities, currently we expect to have cleared all patients waiting longer than 78 weeks and to reduce our 65 week waits to <1,100. Two new modular theatres will be constructed and become operational in January 2024, increasing our day surgery capacity by 50%. National recommendations on the delivery of outpatient activities will be implemented and embedded, pathways will be streamlined and technical developments will enable patients to take more control of their clinical journey.

## Elective Waiting time for Cancer care ~~To be reviewed for alignment with previous content]~~

As explored within the Performance Analysis, above, the considerable improvements in our Cancer performance achieved in 2022-23 will be embedded and continued. Diagnosis of suspected Cancers and the treatment of our patients within 62 days will continue to be our main focus in the coming year. A 4th Endoscopy room will become operational in November and provide the capacity to maintain rapid diagnosis for suspected Gastro-intestinal Cancer for the longer term. The Trust is also fully engaged with Devon System plans to develop Community Diagnostic Centre's where capacity will be created in other critical diagnostic modalities.

The significant program of change in our Elective Care services described above will enable us to build upon our nationally recognised reputation for innovation in Day Surgery and Endoscopic diagnosis. Critical to this will be our ability to attract and recruit the very best people available. We know this will be a challenge and we will be inventive in our approach to ensure that our new facilities can deliver the highest standards of care for our patients.

## Compliance

### Care Quality Commission (CQC)

The Chief Nurse is responsible for ensuring compliance with our registration with the CQC. This is achieved by:

- reporting and keeping under review matters highlighted within inspections
- liaising with the CQC inspectors and senior clinicians and managers in response to any specific concerns raised by the CQC or by patients and members of the public
- engaging with the CQC inspectors in the inspection process and coordinating our response to inspections and any recommendations or actions that arise thereafter
- ~~analyzing~~analysing trends from incident reporting, complaints and patient and staff surveys and sharing the learning from these across our services
- reviewing assurances on the effective operation of controls
- receiving assurances provides by internal audit and any clinical audit conclusions, which provide only limited assurance.
- engaging with the CQC at the standard Quarterly Engagement meetings and Monthly relationship meetings
- a yearly report on the trust's registration to Board

During 2022/23 we had no formal CQC inspection activity but continued our audit and assurance work on ensuring risk assessments were completed fully for each person, within 24 hours of admission to hospital, in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an ISU level, as well as at the Nutritional Steering Group and by exception to the Quality Improvement Group

### Care Quality Commission compliance declaration

At 31 March 2023, we remain fully cognisant of and maintain compliance with our registration requirements with the CQC. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

### Compliance with NHS Foundation Trust condition 4(8)(b)

The assurance process described in this statement allow the Board to issue an accurate Corporate Governance Statement, required under NHS Foundation Trust condition 4(8)(b) of NHS England's provider licence, as applicable during the financial year ended 31 March 2023. It is noted that a new provider licence was issued in the year, applicable 01 April 2023; the requisite reporting for which will be reflected in the annual report and accounts for year ended 31 March 2024.

### Communication with stakeholders

Our communications and engagement team works in partnership with the feedback and engagement team and the membership office to ensure that there are sufficient and robust mechanisms in place to inform the public about, and involve them in, our work.

Together we are committed to ensuring that patients, carers, staff and the public are listened to and have the opportunity to feedback on their experiences while also raising concerns and asking questions about any of our current and future activities. We work closely with our partners in the Integrated Care System for Devon (ICSD) and any formal consultation is led by the ICSD with our support and involvement as appropriate.

Our engagement and communications strategy aims to support meaningful conversations with our people and communities while our patient and service user experience of healthcare strategy helps us to hear and learn better from patient and carer experience.

This year we have undertaken public engagement with people who use our Emergency Department with the support of Healthwatch as well as focused engagement around men's health (again supported by Healthwatch).

A number of forums exist that allow the Board of Directors, Executive Directors and staff at all level to communicate with key stakeholders, including formal Board to Board and Executive to Executive meetings with local commissioners, local health and care providers, Health and Wellbeing Boards, Health Overview and Scrutiny Committees with our local authorities and regular meetings with local MPs and Healthwatch. We also have a growing number of patient and public engagement groups across our services which support us to listen to and learn from our people and communities.

These forums, supported by our other communications, engagement and feedback channels, provide a mechanism for any risks identified by stakeholders that affect us to be discussed for any action plans to be developed.

### Compliance with people strategies and 'developing workforce safeguards

Our people promise and plan was approved by our Board of Directors in 2021. In line with our people promise, we have processes to ensure that short, medium and long-term people plans and people systems to ensure services are safe, sustainable and effective. Further, as part of the safe staffing review, the Chief Nurse and Medical Director confirm that staffing is safe, effective and sustainable and meet the requirements of the National Quality Board and the Workforce Safeguards Guidance (NHSI 2018).

The Board continually reviews the effectiveness of its systems of internal control. The embedding of the strengthened governance framework supports the

provision of evidenced based assurance from ward to Board. The Board reviews the organisation's performance in the key areas of finance, activity, national targets, patient safety and quality and people in the form of an integrated quality dashboard. This includes the regular presentation of performance information against key quality, people and financial metrics to the Board and its Committees. The people section contains information on monthly staff sickness as well as rolling 12-month sickness absence, staff turnover and use of temporary staffing, as well as performance against the annual staff survey. These are high level organisational metrics and data that we will continue to collate, review and analyse each month. These people metrics, together with quality and outcomes indicators and productivity measures form part of the Integrated Performance Report. A more detailed version of the Workforce metrics are reviewed by the People Committee, within the context of delivery of our people promise.

The aim of our people promise is to build a healthy culture at work where our people feel safe, healthy and supported. ~~analysis of our national staff survey results, verbatim comments and informal feedback two~~a

Key priorities were developed based on local evidence: ~~wording to be reviewed for alignment~~

1. define and deliver a consistent, compassionate and Inclusive Leadership & Management approach that is motivating, empowering and encourages accountability
2. making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities.

To deliver on these two priorities, and continually improve the experience of our staff in order to deliver the best possible care, we have identified six deliverables. Under each deliverable are detailed project plans that are reported into our People Promise Programme Board and People Committee~~:~~~~[wording to be reviewed for alignment]~~:

- Co-Create leadership framework & descriptors
- Leadership recruitment and development is based on this framework
- Equipping managers with the essential skills and confidence
- Support organisational reshape using span of control and engagement outcomes
- Workforce transformation programme to deliver clear enabling data and people process
- Development of robust strategic workforce plans and process, driving career pathways, learning/development

In terms of the wider context, we remain fully engaged with the Devon system workforce strategy, of which the main focus is centered on developing a culture and structure that facilitates trust, involvement and innovation and local empowered decision making. There is also work underway to develop a Devon-wide workforce plan in line with the Devon long term strategy. Within Torbay and South Devon we have recruited a strategic workforce planning lead, to ensure alignment to the ICS and development of both short and long term workforce planning in line with our Building a Brighter Future submission requirements.

### Compliance with 'Managing Conflicts of Interest in the NHS' guidance

We have published on our website, an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by us with reference to the guidance) within the past 12 months as required by the '*Managing Conflicts of Interest in the NHS*' guidance published by NHS England.

### Compliance with NHS pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

### Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisations' obligations under equality, diversity and human rights legislation are complied with.

We are committed to providing an inclusive and welcoming environment for all our staff, patients, clients, service users, carers and families. We are striving to create a culture of inclusion for all.

A range of control measures are in place to ensure the organisation complies with its obligations under equality, diversity and human rights legislation. Performance is monitored through the collection of statutory data and action plan which report through the People Committee.

The Board of Directors receives reports on diversity and inclusion issues from the Chief Nurse (patient and service user updates) and the Chief People Officer (people updates). These include any updates or changes in national mandates together with any risks or challenges.

### Compliance with Climate Change Act and the adaptation reporting requirements

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and the adaptation reporting requirements are complied with and in line with NHS net zero targets.

### Review of economy, efficiency, effectiveness, and use of resources

Directors are responsible for putting in place proper arrangements to secure economy, efficiency, and effectiveness in our use of resources. We have established several processes to ensure the achievement of this. These include:

- clear processes for setting, agreeing, and implementing strategic objectives based on the needs of the local population, reflecting the priorities of key partners and the Department of Health and Social Care. This includes a clear strategy for patient, client, service users, carers, and public involvement as well as our governors and public members, providing a key focus for our engagement work within Torbay and South Devon. Established objectives are supported by quantifiable and measurable outcomes
- clear and effective arrangements for monitoring and reviewing performance which include a comprehensive and integrated performance dashboard used monthly in the performance management of health and social care services and reported to the Board of Directors. The integrated finance, performance, quality and people report details any variances in planned performance and key actions to resolve them
- there is also a performance management regime embedded throughout the organisation including weekly capacity review meetings, financial recovery planning meetings, executive reviews of services, budget reviews (undertaken monthly) and regular work to ensure data quality
- Committees consider reports of external regulators and bodies, with improvement action plans developed and their implementation monitored where and as necessary
- through the Finance, Performance and Digital Committee, we have arrangements for planning and managing financial and other resources in place. These are encompassed in the Scheme of Delegation and the Standing Financial Instructions

- we use other benchmarking tools such as the Model Hospital productivity metrics to demonstrate the delivery of value for money and identify opportunities for improvement. We continue to develop our reference cost reporting data to ensure services are being provided as efficiently as possible. For procurement of non-pay related items, we have a clear procurement strategy and collaborate with other NHS bodies to maximise value through the NHS south west peninsula procurement alliance.

### Compliance with information governance requirements

Continuous improvement and maintenance of good information governance standards is a key priority for the Trust. This is reflected in the Trusts commitment to the national standards set out in the Data Security and Protection Toolkit (DSPT), completed annually.

Completion of DSPT demonstrates that we are compliant with the following:

- General Data Protection Regulation (GDPR)
- compliance with the expected data security standards for health and social care for holding, processing or sharing personal data
- readiness to access secure health and care digital methods of information sharing, such as NHS mail and Summary Care Records
- good data security to the CQC as part of the Key lines of Enquiry (KLOEs).

We have appointed key roles to support our commitment to data protection by design and default. These roles are the champions of appropriate data capture, processing, security and sharing by the organisation:

- Senior Information Risk Owner (SIRO), held by Executive Director of Transformation and Partnerships is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level
- Caldicott Guardian, held by Consultant for pain management and Anaesthesia is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
- Data Protection Officer (DPO), held by Head of Records, IG, DP and FOI is the expert in data protection and reports to the most senior levels within the organisation on risks to the privacy of individuals, and threats to the organisation

The recent Information Commissioner’s Audit assessment confirmed a high level of assurance for governance and accountability, with a reasonable level of assurance for data sharing. During 2023 the areas identified for improvement have been actioned, with ongoing work to improve the procurement process, including ongoing assessment of existing contracts.

The Data Security and Protection Toolkit is supplied by NHS Digital to support the performance monitoring of Information Governance. We submitted ‘standards met’ for 2022/23, and expect to meet the same for 2023/24.

Information Governance incidents and risks are recorded on our risk management system. These are monitored by the Head of Information Governance for guidance and support in resolution. Summary reports and highlighted risks are discussed at information governance steering group (IGSG) chaired by the SIRO.

Incidents that score in line with regulated reporting are reported to the ICO – see summary below:

| Description of incident: | Action taken (Investigation) | Lessons learned | ICO Feedback |
|---|---|---|---|
| A major supplier to the healthcare sector (Advanced Computer Software Group Ltd) suffered a cyber-attack that caused significant disruption across the UK. The incident resulted in several IT systems being taken offline. The relevance to our Trust is the Carenotes system which is used for electronic patient record software for children, young people and families | Continuous specialist meetings to recover services, and recover data. | application of multi system providers across the Devon system supported a swift recovery of daily operations. Learning to be included to IT tenders | National impact – reporting aided central assessment of scale of impact for the ICO. No specific response to the Trust |
| Phone call from service user to health visitor. Service user upset because 'patient held record' was not given back to service user when they left the hospital, the hospital had sent record to an unknown person. This person used social media to contact service user to say they had the record. sensitive personal information potentially disclosed. | Under investigation | | |

| Complaints received from the ICO | Outcome |
|---|---|
| Subject Access Request – part refusal of disclosure. The disclosure time frame was delayed, beyond statutory timescales. | Upheld – The ICO approved disclosure redaction but upheld based on timescale breach. |
| Subject Access Request - part refusal of disclosure. The disclosure was delayed beyond statutory timescales. | Upheld – Statutory timescale breached. |
| Query over legal basis for processing of service user data. | Not Upheld - ICO requested the Trust communicate the Privacy Notice and an explanation to the complainant, which was duly done. Bespoke training was delivered, and learning taken to be implemented in future training. |

The Trust is committed to a culture of openness and transparency as evidenced in the wide reporting of incidents. Incidents involving a breach of confidentiality, security, and records management are recorded on our incident reporting system, are assessed by the information governance team, with summary reports presented to the IGSG as a sub group of the Information Management and Technology Group (IM&T).

## Data quality and governance

Performance dashboards are used across the organisational governance structures to give monthly oversight of key metrics covering quality, workforce, performance and finance. Each of the specialist areas has its own processes for assurance on data quality and reporting accuracy. Fortnightly, performance, risk and assurance meetings are held by service leads with oversight from the Chief Operating Officer. Performance benchmarking including model hospital and third-party benchmarking including Dr Foster, 'Gooroo' Planner (referral to treatment data ('RTT') and NHSEI

performance benchmarking is used to triangulate data and support assurance of data quality and reporting accuracy.

~~accuracy.~~

Clinical coding is a key source of intelligence for us, creating an asset that is used as a key intelligence resource, and carries financial implications. During COVID the coding team switched to a home working model which saw a decrease in quality due to staff not having access to paper records. Incident data and medical record audit data can be used to assess the quality of paper medical records. There are recordings of records found to hold documents relating to different patients, incorrectly filed and potentially acted upon, causing a clinical risk. These long-standing issues are recognised across the NHS and are a factor in the electronic patient record (EPR) investment we are making~~..~~. Training is in place to promote paper-based record keeping standards.

The Information Assurance Group, run by the Head of the Data Warehouse assesses data quality in the Trust Information Assets and provides assessment and assurance to the IM&T group, as a route to the Board. A primary focus across the Health Informatics Service (HIS) has been initial consideration in readying the organisation for an EPR development; one area identified for improvement is the data held in the Electronic Staff Record (ESR).

We have previously implemented recommendations from the commissioned PWC review of data quality which was part of the annual plan assurance process. In 22/23, an example of quality assurance work was the commissioning of a third party organisation to assess data quality in waiting lists, this process followed a full governance assessment process including DTAC; outcomes from this work will be delivered in 23/24. Our Data Warehouse team has worked nationally to ensure that the script, pull and disclosure of information is accurate, following the local identification of a national glitch in request and assessment.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, corporate and clinical audits as well as operational and governance reporting mechanisms, supported by the knowledge, capability and accountability of the executive managers and clinical leads, each of whom have responsibility for the development and maintenance of the internal control framework in their respective areas. I have also drawn on performance information available to me, as well as comments made by the external auditors in their management letter and other reports.

I have been advised on effectiveness of the system of internal control during the year by the Board, and its sub-committees: including the Audit and Risk Committee; Quality Assurance Committee; Finance, Performance, and Digital Committee; Building a Brighter Future Committee and People Committee, and in addition the Executive Group and risk group. Where identified, weaknesses are addressed or a plan is put into place to mitigate them, so as to ensure continuous improvement of the system is in place.

Core documentation underpinning our system of internal control (including accountabilities and delegations) include but is not limited to: the Trust Licence and Constitution, Committee Terms of Reference, Matters Reserved to the Board, standing orders, scheme of delegation and standing financial instructions as well as both corporate and operational policy, procedure guidelines and standard operational procedures.

The Board assurance framework, as a mechanism for monitoring strategic delivery in a risk-based way, provides me with evidence of the effectiveness of controls and that any gaps are being addressed with appropriate action. My review has also been informed by the major sources of assurance on which reliance has been placed during the year.

These sources include reviews carried out by our external auditor Grant Thornton LLP, Deloitte LLP, Care Quality Commission, Internal Audit, Good Governance Institute and the Health and Safety Executive.

The following Committees and groups are involved in maintaining and reviewing the effectiveness of the system of internal control:

- the Board of Directors has overall accountability for the governance arrangements, including the committee structure, and ensuring we adhere to our constitution and apply our standing orders, scheme of delegation and standing financial instructions correctly. The Chairs of each of the Board sub-committees present a report to the next available Board meeting for the purpose of providing assurance on matters within its terms of reference. Urgent matters if requiring escalation to the Board are reported by the Committee Chair in the intervening period. The Board has agreed, in conjunction with the Council of Governors, the strategic objectives for the organisation. The Executive Directors have assessed
- the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in our Board assurance framework document reviewed regularly by the Board of Directors;
- the Audit and Risk Committee is responsible for establishing an effective system of internal control and risk management and provides an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity by reviewing the statement on internal effectiveness and Annual Governance Statement. Reports from the internal auditors and external auditor also provide assurance. The Committee also reviews on a regular basis, the risks that are described in the Board assurance framework. The Committee has oversight of and relies on the work of the risk group to monitor the risk management process and risk registers. The Committee has oversight of expressions of concerns and whistleblowing arrangements. The Audit and Risk Committee is chaired by a suitably qualified Non-Executive and membership comprises the Chairs of each of the Board Sub-Committees;
- the Quality Assurance Committee provides the Board of Directors with assurances of clinical effectiveness through scrutiny of patient quality and safety, patient experience, medicines management and staffing. It monitors selected quality metrics and ensures the organisation has robust systems in place to learn from experience. It receives reports from specialist governance groups and Boards e.g. statutory safeguarding partnership boards; patient safety; and serious incidents and undertakes a deep-dive review into a service or specialty at

each meeting. The Quality Assurance Committee is chaired by a Non-Executive Director and reports to the Board of Directors;

- the Finance, Performance and Digital Committee oversees, co-ordinates, reviews and assesses our 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. The Committee provides the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on our financial viability and sustainability. It provides detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board of Directors. It also assesses and identifies risks within the finance, performance and digital portfolio and escalates as appropriate. The Finance, Performance and Digital Committee is chaired by a Non-Executive Director and reports to the Board of Directors;
- the Building a Brighter Future Committee was established in 2020 for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme and to support the successful achievement of the ~~programme's~~programmes investment objectives and realisation of the stated benefits. It also aims to assure the Board of the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable;
- the risk group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the risk management strategy. It promotes effective risk management and compliance and supports maintaining a dynamic Board assurance framework and risk management database where risks are registered. It also ensures local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of our activity where robust controls are not evident in order to raise standards and ensure continuous improvement. The risk group is chaired by the Chief Finance Officer.

My review is also informed by the Head of Internal Audit Opinion which states that satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the ~~organisation's~~organisations objectives, and controls are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives.

During 2022/23, internal audit undertook 16 substantive reviews and a high-level assessment of ~~the~~ our governance arrangements, all of which informed the Head of Internal Audit Opinion for 2022/23. Internal audit reports are received by the Risk Group for review and action and are presented to the Audit and Risk Committee for assurance. Action plans and progress are reported in detail to each subsequent Audit and Risk Committee meeting as part of internal audit's follow-up process. This process includes a programme of review of improvements in practice in response to limited assurance reviews by the Audit and Risk Committee, including presentation of the action plan to the Audit and Risk Committee by the Executive Lead Director. The internal auditor takes a risk-based approach to formulating the annual work plan for agreement with management prior to final approval by the Audit and Risk Committee.

External audit provides independent assurance on the Annual Accounts, Annual Report and the Annual Governance Statement.

Significant internal control issues: [New section to note. Requested by Grant Thornton and compiled with input from ASW]

Gaps in internal control or assurance which arise during the year are identified in a multitude of ways as a result of the effectiveness of our internal controls; three principle ways that any such gaps are captured and reported are through the Business Assurance Framework, Risk Management Framework and audit, both internal and external. Such gaps are identified and corresponding actions are set and managed

Notable matters which impacted on the effectiveness of our internal controls and commentary on corresponding actions taken, which arose during 2022/23 are summarised below:

- The Trust outsources elements of its transactional financial services to two third party suppliers namely NHS Shared Business Services (SBS) and the NHS Electronic Staff Record (ESR) Programme. Assurance on the effective operation of the control environments with these suppliers is gained through various measures, including independent auditors' reports. The national independent audit on the NHS Electronic Staff Record Programme for the period 1 April 2022 to 31 March 2023 has received a qualified opinion. The Trust is satisfied that there are compensating controls at the Trust that are sufficient to mitigate the control deficiencies with the third party and is furthermore assured by the additional procedures performed and conclusion reached by external audit.
- The Head of Internal Audit opinion report noted the following audits as having received Limited assurance:
    - Emergency Preparedness, Resilience and Response (EPRR) – Post Incident Debriefs
    - Medical Staffing – New L2P Job Planning System – Progress with Project
    - Workforce Plan and Ongoing Workforce and Workforce Planning Considerations, Split Opinion (Limited and Satisfactory)
    - Medical Devices Training Records (TBC still draft)
    - Completion of Risk Assessments on Admittance to Hospital (TBC still draft)

These audits have been considered by the Audit Committee and detailed action plans have been identified. These are being reviewed and monitored during 2023/24 by the Audit Committee (reporting to the Board of directors). In addition, the Executive leads, as well as Team as a whole, are reviewing operational progress routinely.

## Conclusion

In concluding my review on the overall system of internal control, I am assured that:

- the Board, Executive Directors, senior management and staff of the organisation, have identified and are managing the risks we face, with escalation of risk events, an effective process for keeping risk scores up to date and flagging any risk and control concerns
- there is an appropriate risk management framework embedded in the organisation along with there being no major concerns from the undertaking of an effective programme of independent, risk-based monitoring
- our internal auditors and other independent assurance providers such as external auditors, have no major concerns from their risk focussed programme of independent assurance.

My review therefore confirms that no significant internal control issues have been identified for the financial year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Liz Davenport, Chief Executive

28 June 2023

## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS OF TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Liz Davenport, Chief Executive

28 June 2023

David Stacey, Chief Finance Officer

28 June 2023

## Appendix A – Biographies of the Board of Directors as at 31 March 2023

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| **Richard Ibbotson Chairman**<br><br>**Appointed:**<br>**June 2014**<br><br>**Reappointed:**<br>**April 2017**<br>**June 2020**<br>**June 2021**<br>**March 2022**<br>**March 2023** | Sir Richard Ibbotson was appointed as Chair in June 2014, shortly after retiring from a career in the Royal Navy. This included periods in command of Britannia Royal Naval College Dartmouth, Commander British Forces Falkland Islands and Deputy Commander-in-Chief Fleet (effectively Chief Operating Officer of the Royal Navy and Royal Marines). He has considerable experience in operating at Board level and dealing with operational pressures and challenging budgets.<br><br>As well as being knighted for his services, Richard is a Companion of the Most Honourable Order of the Bath and holds the Distinguished Service Cross and the NATO meritorious service medal. His academic background includes a degree in chemistry, a master's degree in defence technology, and an honorary doctorate in technology. He also holds other public roles, notably as a Deputy Lord Lieutenant for Devon.<br><br>Richard has been a Governor of Plymouth University and Chairman of the Royal Navy Royal Marines Charity and was a Member of the Armed Forces Pay Review Body.<br>Richard is Chair of the Council of Governors, the Non-Executive Nominations and Remuneration Committee and the Governor Nominations and Remuneration Committee. |
| **Liz Davenport: Chief Executive**<br><br>**Appointed:**<br>**October 2018** | Liz as Chief Executive is responsible for the overall management of Trust activities delivering high quality services to the standards set within the resources available. As Accountable Officer she is responsible for ensuring that the Trust meets all of its statutory duties.<br>Liz started work in the Trust in Torbay in September 2014 and was appointed as the Chief Operating Officer for the Integrated Care Organisation in January 2015. She took a key role in leading the implementation of the integrated care model, including the development of community services. Liz was appointed in October 2018 as the Trust's substantive Chief Executive following a period in the Interim role.<br>Liz has a clinical background, and has been employed in the NHS since qualifying in 1986 as an Occupational Therapist. She has a passion for service improvement and transformation designed to improve outcomes and experiences for people in our communities making the best use of resources and evidence of what works well. Her career started in mental health services where she was involved in the setting up of community services for people with mental health needs. She has subsequently continued to work in a number of NHS organisations across the country leading on a number of service improvement projects in mental health, learning disabilities and social care services. She has also held a broad portfolio of Executive Director positions including Director of Operations, Director of Workforce and Organisation and Deputy Chief Executive in Devon Partnership Trust before making the transition to Acute and Community services in Torbay. |

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| **Chris Balch**<br>**Non-Executive Director**<br><br>**Appointed:**<br>**April 2019** | Chris Balch joined the Board as Non-Executive Director in April 2019. Chris is Emeritus Professor of Planning at Plymouth University and is a Chartered Town Planner and Surveyor. Prior to his academic career he held senior executive positions with an international property advisory company, latterly as Managing Director of DTZ UK & Ireland, now part of Cushman & Wakefield. He has extensive experience of providing consultancy advice to public and private sector clients across the UK and overseas specialising in the planning and delivery of major regeneration projects and programmes.<br>He has been Chair of Basildon Renaissance Partnership, a member of the Council of Essex University, a Director of Torbay Development Agency and Non-Executive Chairman of Hilson Moran, a consultancy specialising in the energy performance of complex buildings. He is currently a member of the Supervisory Board of Ecorys BV, a European policy and research consultancy and is a Trustee and Vice-Chair of South West Lakes Trust. He is Independent Advisor to the Development Committee of Live\|West and will join the Board of LiveWest from September 2023.<br>His interest lies in tackling the underperformance of places and managing positive change within professional organisations and communities.<br>Chris is Chair of the Building a Brighter Future Committee (previously known as the HIP2 Redevelopment Committee). He is also a Board member and Chair of the Trust's subsidiary SDH Innovations Partnership LLP. |
| **Jacqui Lyttle**<br>**Non- Executive Director and Senior Independent Director**<br><br>**Appointed: October 2014**<br><br>**Reappointed: October 2017**<br>**October 2020**<br>**October 2021**<br>**October 2022** | Jacqui Lyttle joined the Board as a Non-Executive Director in October 2014 having spent over 20 years working in the NHS at very senior manager and executive board level before establishing her own healthcare consultancy in 2008. She has a genuine passion for improving care for patients and speaks both nationally and internationally on quality and service improvement, commissioning for outcomes and the management of change within healthcare.<br>Jacqui has an interest in the management of pain and is an executive member of the Chronic Pain Policy Coalition a standing committee of an all Parliamentary Party Advisory Group. Other areas of interest include rheumatology, dermatology, endocrinology, cardiology and oncology with Jacqui working extensively in these areas across the UK<br>Jacqui continues to work actively within the NHS, undertaking service reviews and leading on large scale quality improvement programmes and acts as an executive commissioning advisor to several Royal Colleges and health related charities including Action on Pulmonary Fibrosis, Neuroendocrine Cancer UK and Diabetes UK. Jacqui is a lecturer on the NHS for Health Education England and has a keen interest in developing future clinical leaders.<br>She is also an NHS advisor to several professional bodies including the British Society for Rheumatology and the British Association of Dermatology. Jacqui is Chair of AGE UK Torbay.<br>Jacqui is Chair of the Quality Assurance Committee and the Torbay and South Devon NHS Charitable Funds Committee and is the Trust's Senior Independent Director. |
| | Vikki Matthews joined the Board as Non-Executive Director in December 2017. She is currently the Executive Director for People and Culture at Health Education England, prior to which she was the Executive Director for People and Comms at South Western Ambulance Service. Previously she ran her own coaching and consulting business. She was also the Chief Talent Officer for Plymouth University and held several Global and EMEA-wide Director level roles for Nike based in Holland and the USA. |

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| | Vikki Chaired a Multi Academy Trust based in Plymouth from 2012-2017 and is currently the Company Secretary for a small education charity in Brighton.<br>Vikki is Chair of the People Committee |
| **Paul Richards**<br>**Non- Executive Director**<br><br>Appointed: **November 2017**<br><br>Reappointed:<br>**November 2020** | Paul Richards joined the Board as a Non-Executive Director in November 2017.<br>Highly experienced at Board level in both public and private sector organisations, Paul applies strategic insight and constructive challenge on complex organisational issues and drives improvements in performance and outcome. He has been director and SRO for numerous Programmes in the EPR and Clinical Systems space ranging from design, build, test and through to implementation and benefits realisation. He has been a leader of several major international EPR and clinical supplier companies and within large professional services organisations and has worked extensively internationally.<br>Paul has a strong track record of leading multiple large, technology based/digital businesses to sustainable growth and success through working in partnership with stakeholders and boards in a variety of board roles. He has decades of experience working internationally, across the private and public sector and has repeatedly been called in to bring in new ways of working, governance arrangements and renewed focus. Throughout his career Paul has served on the European HIMSS Governing Council, TECHUK (formerly INTELLECT) Health Council, he is a Fellow of: the British Computer Society (FBCS); the Royal Society of Arts (FRSA); and the Institute of Directors (FIoD).<br>Paul has a passion for improving and connecting health and social care though digital adoption and health tech and the benefits these solutions bring to clinical outcomes, the patient and service user experience and to clinicians and carers. He continues to have a variety of business interests.<br>Paul is a Chair of the Torbay Pharmaceuticals Board and a member of the Building a Brighter Future Committee. |
| **Robin Sutton**<br>**Non- Executive Director**<br><br>Appointed:<br>**May 2016**<br><br>Reappointed:<br>**May 2019** | Robin Sutton joined the Board as Non-Executive Director in May 2016. Robin is a Chartered Accountant with over thirty years of financial experience gained at a senior level for both private and public enterprises in both executive and Non-Executive Director roles. Robin has previously held Non-Executive Director and senior positions at several multi-national organisations including Sifam, JDS Uniphase, CompAir Holman, Rolls-Royce PLC and Deloittes.<br>Robin's interest in healthcare stems from a variety of different factors, ranging from consulting for Lowell General Hospital in Massachusetts through to working with Novartis in developing ultrafast fibre laser technology for eye surgery. He has also been heavily involved with care services and social care covering a spectrum of services from meals on wheels, day care, supported living and residential care. Robin currently has local business interests in the care industry and is the Chair of Devon Care Homes Collaborative.<br>Robin has also enjoyed completing an Innovating in Healthcare program with Harvard University with a team of like-minded people looking at smart phone applications in the field of dementia. Robin is Chair of Audit Committee, Non-Executive Director of Torbay Pharmaceuticals and a Director of the Trust's subsidiary SDH Developments Limited. |

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| **Siân Walker-McAllister**<br>**Non-Executive Director**<br><br>**Appointed:**<br>**September 2022** | Siân Walker-McAllister joined the Board as a Non-Executive Director in September 2022. Siân is an independent social care consultant, a Registered Social Worker, and an Associate of the Association of Directors of Adult Social Services. A former local authority Director of Health & Social Care, Siân has over 40 years' experience of working in social care in London, the South-West and in Wales.<br>As a former Housing Association Director, Siân was responsible for the delivery of a wide range of commissioned social care services as well as supported housing in London and the south-east and in Devon. Alongside her role as a Non-Executive Director with us, Siân currently chairs two Safeguarding Boards in the south-west region, and co-chairs the National Safeguarding Adult Board Chairs' Network.<br>Siân is concluding two terms of office as a Commissioner for the Jersey Care Commission in 2023. Siân has a wealth of experience of non-executive director roles across a local authority, the NHS, Housing Associations, and the voluntary sector.<br>Siân is driven by a passion for excellence, ensuring all services to vulnerable people are person-centred, easy to access and importantly promote independence, while ensuring people are safe. |
| **Richard Crompton**<br>**Non-Executive Director and Vice Chair**<br><br>**Appointed:**<br>**August 2022** | Richard joined the Board as a Non-Executive Director in August 2022. Richard was a police officer for 32 years beginning his career in the Metropolitan Police. He served for 19 years in Devon and Cornwall holding various ranks in Plymouth, Torbay and Exeter. He transferred to Cumbria Constabulary in 2001 before moving to Lincolnshire Police as Deputy Chief Constable and later as Chief Constable. Richard held national responsibility for policy in relation to Vulnerable Adults, Vulnerable and Intimidated Witnesses, Wildlife and Environmental Crime, and for Neighbourhood Policing and Partnerships. He chaired the East Midlands Association of Chief Police Officers leading a major programme of collaboration across the five forces. In August 2012 on retiring from policing Richard was appointed chairman of University Hospitals Plymouth NHS Trust and served in that capacity until July 2022. He has also chaired the Adult Safeguarding Boards of Somerset and Wiltshire, and was the independent chairman of the safeguarding panel for Dimensions. Richard is now a non-executive director on the Dimensions Group Board, and as part of his responsibilities he chairs the Board of Discovery Somerset, a Social Enterprise and Dimensions subsidiary which provides support for learning disabled and autistic adults in Somerset, a national provider of personalised social care services for people with learning disabilities and autism. Partnership working, addressing inequalities and improving services to the most vulnerable have been constant themes throughout his career.<br>Richard is chair of Finance, Performance and Digital Committee and Vice-Chair for the Non-Executive Nominations and Remuneration Committee. |
| **Peter Aitken: Associate**<br>***Non-Executive Director***<br><br>**Appointed:**<br>**January 23** | A medical graduate of the University of Glasgow in 1987 Peter moved to London for post-graduate training at the Royal Free Hospital then St George's Hospital Medical School.<br>He completed vocational training in General Practice and worked as a Primary Care Physician in Accident & Emergency and as mental health adviser to NHS Tooting Walk-In-Centre and NHS Direct Croydon at their inception.<br>Retraining in the psychiatry of general hospital patients he was consultant liaison psychiatrist at St George's Hospital London and University Hospitals Southampton before moving to Exeter in 2002. His career interests are the psychological care of medical patients and suicide prevention. He has published in both fields leading national policy in the design of liaison psychiatry services and |

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| | management of high-risk locations for which he was recognised as 'Psychiatrist of the Year' in 2016.<br>He is Chief Medical Officer at Sussex Partnership Foundation NHS Trust and National Clinical Director for the NHS England DASV Program.<br>He is past Chair, Faculty of Liaison Psychiatry, Royal College of Psychiatrists and previously trustee at Anthony Nolan and member of the steering group for the Zero Suicide Alliance.<br>He is Chair of the RNLI Medical Advisory Committee, mental health adviser to the National Association of Primary Care, trustee at the Lions Barber Collective and He is a practicing Consultant Psychiatrist. |
| **Ian Currie**<br>**Executive Medical Director**<br><br>**Appointed:**<br>**September 2020** | Ian is responsible for provision of high quality, safe and effective care and providing medical input into shaping strategy.<br>Ian joined the Trust in 1998 as Consultant Vascular Surgeon, having previously been Senior Registrar in General and Vascular Surgery at Plymouth Hospitals NHS Trust. Prior to this, Ian worked at several hospitals in the South West, including Cheltenham General Hospital, Bristol Hospitals, Gloucestershire Royal Hospital, as well as John Radcliffe Hospital in Oxford. This period also included a year spent working in Sydney, Australia.<br>Ian has a long-standing interest in integrated care models, urgent and emergency care and elective care, and has held a range of appointments in educational and leadership roles throughout his career. He has a strong interest in prevention and previously developed and led the South Devon and Exeter Abdominal Aortic Aneurysm screening programme. |
| **Adel Jones**<br>**Director of Transformation and Partnerships**<br><br>**Appointed:**<br>**July 2019** | Adel joined the Trust Board in July 2019 and holds the Executive accountability for; the development of the Trust Strategy, the delivery of Improvement and Innovation, both within the Trust and across the ICS and Local Care Partnership, the delivery of the Trust Digital Strategy and the leadership for the Health Informatics Service, Communications and Engagement, strategic partnerships and the delivery of the Building a Brighter Future (New Hospital Programme).<br>Adel has significant experience of large-scale transformational change across health and social care, developing new models of acute and emergency care, integrating health and care services in the community and driving operational efficiency through new ways of working. With extensive experience in strategic planning, workforce re- design, quality improvement and operational management, Adel has worked across many sectors over the last 25 years, including primary care, strategic health authority, acute and community health and care services. Before joining us in 2019, Adel was the Integration Director at the Royal Devon and Exeter Hospital.<br>In leading the digital portfolio, Adel has a keen interest in digital innovation and is joint chair of the NHS Providers Digital Boards Programme and is the Senior Information Risk Owner for the Trust. |
| **Deborah Kelly**<br>**Chief Nurse**<br><br>**Appointed:**<br>**August 2020** | Deborah Kelly is responsible for the quality and safety of the care provided by the Trust, including infection prevention.<br>Deborah joined the Trust in August 2020 and as Chief Nurse leads on several objectives including quality, professional practice, patient experience, safeguarding, and clinical governance. Deborah qualified as a nurse in 1985 and has spent the majority of her career working in London in a range of leadership roles in community, acute and tertiary services. Deborah was previously Deputy Chief Nurse for Barts Health NHS Trust and more recently returned from working in the Middle East as the Deputy Chief Nurse and Chief Nurse for Informatics at Sidra Medicine, Doha Qatar.<br>In her previous roles she has devised quality, clinical governance and patient experience strategies, ensuring that staff and patients |

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| | voice are heard. Deborah feel passionately around creating opportunities to empower staff and has successfully introduced models of shared governance, enabling staff led change and improvement. Her work around patient and public engagement was cited as best practice internationally by the Canadian Agency for Drugs and Technologies in Health 2017 and she has successfully partnered with the Kings Fund in 2015/16 through the Collaborative Pairs Programme. |
| **David Stacey**<br>**Chief Finance Officer & Deputy CEO**<br><br>**Appointed:**<br>**January 2020 (CFO)**<br>**July 2021 (DCEO)** | Dave Stacey is responsible for the Foundation Trust's financial planning and performance, workplace environments and capital & commercial development. He is also the Deputy Chief Executive of the Trust.<br>Dave joined the Foundation Trust in January 2020 from North Middlesex University Hospital, where he spent three years as Director of Finance leading a successful financial turnaround, securing significant external funding for large capital programmes and overseeing a major digital transformation programme.<br>His previous roles include Deputy Director of Transformation at Chelsea and Westminster NHS FT, where he played a pivotal role in the successful integration of West Middlesex Hospital, and Director of Strategy at England's biggest mental health trust, West London Mental Health. Prior to joining the NHS in 2013, he spent 7 years in KPMG's healthcare team, delivering audit and advisory services to a range of UK and international healthcare organisations. |
| **Jon Scott**<br>**Interim Chief Operating Officer**<br><br>**Appointed:**<br>**October 2022** | Jon Scott is responsible for developing, implementing and ongoing oversight of health and social care delivery for our Torbay and South Devon population. He is also responsible for overseeing our health and safety and security management functions.<br>Jon has worked within healthcare systems since 1995. Jon's most recent role was as Chief Operating Officer for the Bristol, North Somerset and South Gloucestershire Integrated Care Board. Prior to that Jon has been a Chief Operating Officer of 17 Acute trusts of all sizes and make-up including Barts Health, Addenbrookes, Portsmouth and Manchester.<br>Jon has a reputation for operational improvement and has worked with teams to win several national awards and been recognised by the Secretary of State for Health and Social Care. Jon is a faculty member of the Institute for Healthcare Improvement and of Deloittes (New Zealand). |
| **Michelle Westwood**<br>**Chief People Officer**<br><br>**Appointed:**<br>November 2022 | Michelle leads the People Directorate and is responsible for the delivery of our People Promise – to build a culture at work where our people feel safe, healthy and supported, and where there is a consistent, compassionate and inclusive leadership and management approach, that is motivating, empowering and encourages accountability.<br>Michelle is a strategic HR leader, with significant knowledge of workforce matters, including introducing new ways of working, leading retention campaigns, and in the development of programmes to support leadership development, capability and organisational culture. She joined us in November 2022, following a 20-year career in the Royal Navy where her last appointment was the Programme Director of the Royal Navy's People Transformation programme.<br>Michelle is deeply passionate about her role and enjoys building and stimulating teams, disrupting the accepted order or status quo to achieve sustainable success for people and organisations. Michelle holds a PhD in personal leadership development, and is a Fellow of the Chartered Institute of Personnel and Development. She also holds Non-Executive Director positions as Trustee of two military charities that aim to support serving military, veterans, and their families, for life. |

| **Emily Long**<br>**Director of Corporate Governance and Trust Secretary**<br><br>**Appointed:**<br>November 2021 | Emily Long, Director of Corporate Governance and Trust Secretary (non-voting Board member)<br>Emily joined the Trust as Director of Corporate Governance and Trust Secretary in November 2022.<br>Emily is a qualified Chartered Company Secretary and Chartered Legal Executive, specialising in corporate law, corporate governance, organisational structure, stakeholder engagement and risk management. As an experienced dual qualified corporate services professional, Emily brings a wealth of experience having worked in this capacity since 2010 in a number of different sectors: including professional services, aerospace and defence, housing, marine and events. Most recently working for Leonardo, a large international aerospace and defence and supporting the review of their corporate governance, implementing a revised Board and Committee framework, supported by a new delegation's protocol and adoption of a new Code of Governance, the Wates Principles. |
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| **Dr Joanne Watson**<br>**Health and Care Strategy Director**<br><br>**Appointed:**<br>**February 2021** | Joanne is responsible for delivering our health and care strategy which focuses on making sure our services meet the current and future needs of our people while supporting them to live well. Her unique Board-level position showcases our innovative approach to providing integrated care and ensuring the best use of the monies we will receive from the Government's New Hospital Programme. We are proud to be one of only 40 recipients of this once in a generation programme which will support us to make a real difference in how we deliver services with, to and for our people.<br>Joanne is also the Director of Infection Prevention & Control. Taking on this role in June 2020, near the start of the COVID 19 Pandemic has required flexibility and the need to make decisions on limited information/ evidence. Our results and outcomes to date compare favourably to the national picture,<br>Joanne joined us in 2016 as Deputy Medical Director and Consultant Physician in Acute Medicine. She is an accomplished medical leader with extensive strategic and operational experience which she has gained over many years as a senior clinician in a range of organisational and system leadership roles.<br>Joanne held a twelve months fellowship working at the world leading Institute for Healthcare Improvement using quality improvement skills gained there in her daily work. She has been instrumental in areas of national policy such as the central role of patient experience and improvement in maternity services.<br>Joanne qualified as a doctor in 1991, graduating from London University. Prior to joining us she was a consultant at Taunton and Somerset NHS Foundation Trust in endocrinology and diabetes. She has held positions with the King's Fund, Royal College of Physicians and the South West Academic Health Science Network. |

## Appendix B – Further information and contact details

To see our annual reports and accounts

You can look on our website www.torbayandsouthdevon.nhs.uk or request a copy by writing to the Foundation Trust Office, Hengrave House, Torbay Hospital, Torquay, TQ2 7AA. Large print or other formats are available on request.

To obtain additional information available under the Freedom of Information Act, refer to our public website at www.torbayandsouthdevon.nhs.uk For information not available on our public website, contact the Freedom of Information Office at Torbay Hospital on 01803 654868 or email dataprotection.tsdft@nhs.net

To hear more

During the COVID-19 pandemic, we have been holding all corporate meetings, including Board meetings and Council of Governors' meetings virtually. Once the government guidelines for the NHS enable us to meet in person we will revert to holding meetings in public. In the meantime, the public can access recordings of our Board meetings via our website.

For further information contact the Foundation Trust office on 01803 655705 or email foundationtrust.tsdft@nhs.net

To tell us what you think

About this annual report or our forward plans, contact the Communications Office on 01803 217398 or email communications.tsdft@nhs.net

To help us to improve our services

There are opportunities offered through our membership, patient involvement, our League of Friends or through donations. Contact:

- Foundation Trust Office on 01803 655705 or email foundationtrust.tsdft@nhs.net
- League of Friends on 01803 654520 or website www.thlof.co.uk
- Torbay and South Devon NHS Charitable Fund (Registered Charity No. 1052232) c/o the Charitable Funds Manager, Regent House, Regent Close, Torquay, TQ2 7AN
- The NHS across South Devon benefits enormously from the work of hundreds of volunteers, giving practical support or fundraising. If you are interested in joining our volunteers, we would welcome your enquiry. Sincere thanks to the hundreds of volunteers who support Torbay Hospital and our community and adult social care services. Contact: Voluntary Services Coordinator on 01803 656272

To complain, seek advice or information about aspects of your care our Patient Advice and Liaison Service (PALS) / Feedback and Engagement Team may be able to assist. Contact: Telephone 01803 655838 | Free phone 0800 028 2037 | Email tsdft.feedback@nhs.net

*To access your health records*

An application form can be obtained for records held by Torbay and South Devon NHS Foundation Trust. You may be charged a fee.

Contact: Data Protection Office on 01803 654868 or email dataprotection.tsdft@nhs.net

To find out about joining our team

As a recruit or returning to work after a break.
Contact: Recruitment on 01803 654120 or email tsdft.workwithus@nhs.net

For work experience placements

Contact: email tsdft.workwithus@nhs.net

For general health queries

Contact NHS advice by telephone on 111

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| **Report title: Presentation of the Trust's unaudited 2022/23 Financial Statements** | | **Meeting date: 28th June 2023** |
|---|---|---|
| **Report sponsor** | Chief Financial Officer & Deputy Chief Executive | |
| **Report author** | Assistant Director of Finance | |

## 1.0 Introduction

1.1 The initial draft Financial Statements were presented to the Audit Committee and FPDC during May 2023. A further updated set of financial statements were presented to Private Board on 12th June 2023. Since that date the audit of the financial statements has further progressed and a number of minor amendments have been made to the statements. Although the audit of the Financial Statements is not yet concluded, The Trust anticipates that no further adjustments will be required to the financial statements and therefore the Trust Board is being presented with the final draft for review and approval.

## 2.0 Discussion

2.1 The values and balances presented in the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cashflow have not been adjusted during the course of the audit and remain the same as reported to Private Board on 12th June 2023.

2.2 During the course of the audit there have been a number of minor presentational adjustments that have been both external audit led recommendations and corrections needed identified by the Trust's Finance department team.

2.3 Since the Financial Statements were presented to the Private Trust Board on 12th June 2023 the following modifications have been made: -

- Pages 3 to 8 – Inclusion of draft external audit opinion.
- Page 33 – Operating Expenditure, enhanced disclosure of the external audit fees.
- Page 47 – Right of Use Assets note to accounts. Adjustment to memorandum lines of movements associated with DHSC assets and inclusion of a note that describes the inclusion of the Dartmouth Health & Well Being centre that was an Asset under Construction as at 31st March 2023.
- Page 52 – Trade Payables. Net reduction in value of creditors with DHSC bodies totalling £248k as a consequence of the national Agreement of Balances exercise. An equal and opposite adjustment has been made to Non – NHS creditors within the financial records.

- Page 65 – Special Payments. Increase value of Ex-Gratia payments by £4,000 and quantity of payments by one. This being a commercial based settlement of a claim identified during the course of the audit.

2.4 The Trust Board is asked to note that the page numbering within the financial statements will be adjusted to follow the sequence of the Annual Report when the two documents are combined.

## 3.0 Recommendations

3.1 The Trust Board is asked to review and approve the Financial Statements.

**Appendix A**

# Torbay and South Devon NHS Foundation Trust

## Annual accounts for the year ended 31 March 2023

# Provider accounts template - group accounts

### Version: 0.2 (issued March 2018)

## Background to this accounts template

This accounts template has been developed by NHS Improvement for use by NHS providers (FTs and NHS trusts) and is entirely optional for use.

The accounts prepared by NHS trusts and NHS foundation trusts should comply with the Department of Health and Social Care's Group Accounting Manual (GAM) (and NHS Improvement's *NHS Foundation Trust Annual Reporting Manual* (FT ARM) for foundation trusts). This template has been developed to assist trusts to meet these requirements. NHS Improvement has no current intention of mandating use of this accounts template in future periods.

The requirements for a provider's accounts are set out in chapter 4 of the GAM. This optional accounts template does **not** form part of Monitor's accounts direction to NHS foundation trusts or DHSC's direction to NHS Trusts. If at any point this template appears inconsistent with the GAM, the GAM is the primary source of direction. Any such inconsistency would, however, be unintentional as the purpose of this template is to assist providers in complying with the GAM when determining the format of their accounts.

We recognise that every trust is different, and will have slightly differing disclosure requirements. As such the spreadsheet is entirely unprotected: in using this tool you will need to hide rows/columns as appropriate or you may wish to aggregate immaterial rows or columns and update the mapping to the TAC schedules. As such NHS Improvement cannot guarantee that a set of accounts prepared using this tool will be compliant with the GAM to an extent that will satisfy the trust's auditors. In using this tool trusts will need to adapt it for local circumstances and NHS Improvement accepts no responsibility for the accounts that are produced.

The last tab of this template, tab 'Staff report tables', contains tables for disclosures that should be included in the annual report and not the accounts (per the FT ARM paragraph 2.80 and GAM paragraph 3.57).

## Trust and Group template versions

Many trusts prepare group accounts, as they consolidate an NHS charitable fund or other subsidiaries. Many other trusts do not prepare group accounts. As such there are two versions of this template:

**Trust accounts**: This is a single entity version of the accounts template, with the figures linked to the totals in the TAC schedules.

**Group accounts**: This version should be used by trusts preparing group accounts. The Group numbers are linked to the total column of the TAC schedules. The Trust numbers are not populated and you can link these either to your own working papers. For those who consolidate a charity but no other subsidiaries, the 'Group without charity' columns in the TAC schedules will provide the 'Trust' numbers you can link to if you wish. Alternatively you may have your own working papers for the consolidation and replace the source formulas for both the Group and Trust numbers.

Except for the presence of separate Group and Trust columns/tables in the first version, the two versions are the same.

The Group version of the template assumes that the Trust takes advantage of the Companies Act exemption repeated in the GAM (paragraph 5.9) which allows the parent (i.e. Trust) statement of comprehensive income and related notes to be omitted. The SOCI and its supporting notes therefore omit 'Trust' columns. Some trusts may wish to add these back in, or in some cases add additional disclosure explaining what the difference between group and trust numbers would be.

For notes where Group and Trust should be included, paragraph 5.10 of the GAM states "*Where the entity determines that the difference between the ‘Group’ and ‘Parent Entity’ numbers is immaterial for a particular note, the ‘Parent Entity’ version of that note may be omitted from the accounts. The omission and the extent of the immaterial differences should be explained.* " This template has been prepared with Group and Trust versions of all balance sheet notes, which the user may wish to amend.

## How to use this accounts template

This accounts template is designed to be easy to work with in Microsoft Excel, but is also formatted in such a way that when printed, the end result is a presentable set of accounts. Different local printers will change how page margins work and some editing of column widths in particular may be required to achieve the right formatting for printing for each user.

The accounts template is linked to an TAC schedules within the PFR file. Cells linked to the TAC schedules contain defined file paths which are easily updated by the trust if you choose to map cells differently.  The file as issued contains links directed at dummy TAC schedules held by NHS Improvement.  **When opening the file for the first time, you should select 'do not update links' when prompted.**

Follow the instructions below to direct the links to your local TAC schedule.

## Step 1: Link the accounts template to your PFR file

As a starting point you should update the information on the Settings sheet. Then, you need to change the source file for the links as follows:

1. Select the 'Data' tab on the ribbon at the top of Excel (if this tab is not visible it may need to be added by customising the ribbon in excel options)
2. Within the 'Connections' section, select 'Edit Links'.
3. In the dialogue box that appears, highlight the existing source file (the dummy file) and select 'Change Source'.

4. Navigate to your locally saved PFR file and select.
5. All links within this workbook should now be redirected to your local file. Due to the number of links this may take some time. Please be patient and do not attempt to perform other tasks in excel at the same time.

## Step 2: Check that the PFR linking is working and the accounts hold together

In preparing this accounts template we have linked cells to the TAC schedules but you should verify that these are correct, and that nothing has been affected by changing the link to your PFR file.

There are no validation checks within this accounts template, so at this point we recommend you review the document for reasonableness (not presentation at this stage) - checking that note totals agree between the TAC schedules and accounts, checking that primary statements are accurate, and so forth.

## Step 3: Tailor the document to become your accounts

Tailoring the document may involve some or all of the following:
◦ aggregating rows or columns within disclosure notes - care then needs to be taken to update the PFR mapping

◦ hiding /deleting unnecessary columns or rows - for example unused categories of intangible asset. Care then needs to be taken to ensure that total formulae still work and column widths for row descriptions may need to be changed to ensure tables are right aligned on the page when printed.

◦ hiding /deleting whole notes or sheets in some cases - then need to check that the primary statements are unaffected and update note numbering. Please read Step 4 below in relation to note numbering.
◦ tailoring existing notes where manual inputs/updates are required. [These are identified by red text in square brackets]
◦ adding in extra notes
◦ updating accounting policies - this template includes the example accounting policies issued by NHS Improvement. These require local tailoring or replacing with the trust's own accounting policy disclosures.

## Step 4: Presentation

Note numbers for each note use hidden text in column A to compute the note number adding on from the last note. Where you have added or deleted a note, this formula will need updating in the subsequent note, but then all subsequent notes will renumber. Note references on the primary statements are linked to the hidden numbers in column A so should update automatically when notes are updated. Note references within the example accounting policies are highlighted as red text and these should be updated locally.

In Print Preview mode, you can see how the accounts template will look when printed. Each worksheet (tab) of the file should be checked individually for print preview. If necessary, adjust the column widths on a tab to improve how the document fits on a page. Add/amend page breaks within a tab if necessary (most easily done from page break view).

There are currently no headers and footers set in the template. The Trust may wish to insert the name of the Trust into the header - this is not currently done because of limitations in Excel not making it simple to link this to a cell for the user to edit. If you wish to add headers of footers, highlight the desired worksheets and edit the header/footer tab in the Page Setup box, which is accessible from the Page Layout tab of the ribbon > Margins > Custom margins > Header and footer tab. These options can be set for each tab individually, or for a collection of sheets at once if these tabs are selected when the Page Setup options are amended. Please note that if these settings are changed with multiple sheets selected, all of the settings in the dialog box are applied to the selected sheets - including page orientation. Therefore to assist the user if you wish to change headers/footers for multiple sheets, sheets that are set to landscape orientation are coloured light blue for ease of identification.

The trust may wish to add the page number as a footer. Follow the instructions above for adding a footer. As the accounts follow the annual report, you may not wish to start the accounts page number at 1. In order to change this firstly click on the first tab you want to have a page number, select the Page Layout tab from the ribbon > in the page setup section select the small arrow in the bottom right hand corner > a pop up box will appear, on the Page tab change the last option 'First page number' to whatever page number you want > click 'ok'. All subsequent tabs will follow this page numbering system.

## Step 5: Submission of accounts to NHS Improvement

Where the trusts opts to use this template as a basis for their annual accounts, links to the PFR file (and all other working papers) should be broken before uploading the file to the trust's NHSI portal (for both the draft and final accounts submission). This will prevent #REF! errors appearing when NHS Improvement attempts to view the accounts. Links to the PFR file can be broken as follows:

1. Select the 'Data' tab on the ribbon at the top of excel (if this tab is not visible it may need to be added by customising the ribbon in excel options)
2. Within the 'Connections' section, select 'Edit Links'.
3. In the dialog box that appears, highlight the PFR source file (and any other linked working papers in turn) and select 'Break Link'.

## Feedback and comments

Your comments on this tool are very welcome. In future years we would like to explore adding additional functionality to the tool: please get in touch if you have any comments.

Please send any comments to provider.accounts@improvement.nhs.uk

# Provider accounts template - group accounts

**Inputs**

| | |
|---|---|
| MARSID | SOUTHDEVON |
| Name of provider | Torbay and South Devon NHS Foundation Trust |
| Provider status | FT |
| Date of year end (dd/mm/yyyy) | 31/03/2023 |
| Start of current year (dd/mm/yyyy) | 01/04/2022 |
| Comparative year end (dd/mm/yyyy) | 31/03/2022 |
| Start of comparative year (dd/mm/yyyy) | 01/04/2021 |
| Year for financial reporting (20XX/YY) | 2022/23 |
| Year for comparative year (20XX/YY) | 2021/22 |
| Year for year end (20XX) | 2023 |
| Year for comparative year (20XX) | 2022 |
| Opening Year (20XX) | 2022 |
| Next financial year (20XX/YY) | 2023/24 |
| Date of approval of financial statements (dd/mm/yyyy) | 28th June 2023 |

**Updating links:**
This file contains links to a dummy PFR file. To update the links to your locally completed PFR select 'Data' on the ribbon and within the 'Connections' section select 'Edit Links'. In the dialogue box, select the existing source (linked to a dummy file) and choose 'Change source'. Then navigate to where your local TAC file is saved and select. This will redirect all links in this workbook to your trust's TAC file.

**Links should be broken before submitting this file (as draft or audited) to NHS Improvement via your portal.**

**Torbay and South Devon NHS Foundation Trust**

## Foreword to the accounts

These accounts, for the year ended 31 March 2023, have been prepared by Torbay and South Devon NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

**Signed** ……………………………………………

| | |
|---|---|
| **Name** | **Liz Davenport** |
| **Job title** | **Chief Executive** |
| **Date** | **28th June 2023** |

# Independent auditor's report to the Council of Governors of Torbay and South Devon NHS Foundation Trust

## Report on the Audit of the Financial Statements

### Opinion on financial statements

We have audited the financial statements of Torbay and South Devon NHS Foundation Trust (the ‘Trust’) and its subsidiary (the ‘group’) for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2023 and of the group’s expenditure and income and the Trust’s expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) (“the Code of Audit Practice”) approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the ‘Auditor’s responsibilities for the audit of the financial statements’ section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer’s use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group’s and the Trust’s ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor’s opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer’s conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the group and Trust’s financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust’s disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

**Other information**

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

**Other information we are required to report on by exception under the Code of Audit Practice**

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2022/23 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

**Opinion on other matters required by the Code of Audit Practice**

In our opinion

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

**Responsibilities of the Accounting Officer**

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2022/23, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

**Auditor's responsibilities for the audit of the financial statements**

*Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.*

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit and Risk Committee, concerning the group and Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - high risk and unusual journals;
  - management estimates including land, buildings and dwellings valuations for indicators of management bias;
  - fraudulent revenue recognition – we rebutted income recognition under block contract arrangements, where income could be verified to agreements with third parties. For other
- Our audit procedures, which related to the Trust only, involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;

  - journal entry testing, with a focus on high risk and unusual journals, including those journals processed by senior officers, year end journals created at the weekend, late posted journals, journals posted officers with super-user access, journals with blank descriptions, journals that appeared to be unauthorised, journals with related party entities identified through a review of the register of interests and journals that contained other criteria that we determined presented a higher risk:
  - testing income relating to Torbay Pharmaceuticals to supporting evidence on a sample
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building and dwellings valuations;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communicated with management and the Audit Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue, and the significant accounting estimates related to land and building valuations.
- Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- *In assessing the potential risks of material misstatement, we obtained an understanding of:*
  - *The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.*
  - *The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.*
- *For components at which audit procedures were performed, we requested component auditors to report to us instances of non-compliance with laws and regulations that gave rise to a risk of material misstatement of the group financial statements. No such matters were identified by the component auditors.*

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: *www.frc.org.uk/auditorsresponsibilities* . This description forms part of our auditor's report.

## Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Torbay and South Devon NHS Foundation Trust

**Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in respect of the above matter except on 27 June 2023 we identified two significant weaknesses in how the Trust plans and manages its resources to ensure it can continue to deliver its services.

- The Trust's savings target for the year ending 31 March 2024 is considerably higher than in previous years and contains significant risks to delivery. This is a consequence of the Trust not fully developing savings plans during the year ending 31 March 2023. We recommended that the Trust continue to reassess the level of risk within its savings plans in conjunction with its system partners to ensure that it is underpinned by robust assumptions and is aligned with the its workforce and activity plans. Progress against the savings target and remedial action to address shortfalls should be reported to the Board.
- The Trust's financial position at 31 March 2023 and financial plan for the year ending 31 March 2024 indicates a deteriorating financial position. The Trust does not yet have an agreed medium term plan with local healthcare system partners to make the Trust financially sustainable over the medium term. We recommended that the Trust work with its system partners to develop a credible financial plan to enable it to achieve financial stability over the medium term.

**Responsibilities of the Accounting Officer**

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

**Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

## Report on other legal and regulatory requirements – Certificate

**Torbay and South Devon NHS Foundation Trust**

*We certify that we have completed the audit of the financial statements of Torbay and South Devon NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.*

**Use of our report**

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

*Signature:*

**Barrie Morris**

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

Date 28th June 2023

**Torbay and South Devon NHS Foundation Trust**

# Statement of Comprehensive Income for the year ended 31 March 2023

| | | Group | |
|---|---|---|---|
| | | Year Ended | Year Ended |
| | | 2022/23 | 2021/22 |
| | Note | £000 | £000 |
| Operating income from patient care activities | 3 | 584,635 | 543,680 |
| Other operating income | 4 | 59,437 | 57,860 |
| Operating expenses | 5 | (660,107) | (592,287) |
| **Operating (deficit) / surplus from continuing operations** | | **(16,035)** | **9,253** |
| Finance income | 10 | 723 | 19 |
| Finance expenses | 11 | (3,026) | (2,896) |
| PDC dividends payable | | (5,835) | (4,549) |
| **Net finance costs** | | **(8,138)** | **(7,426)** |
| Other losses, net | 12 | (138) | (639) |
| Corporation tax expense | | (22) | (22) |
| **(Deficit) / Surplus for the year from continuing operations** | | **(24,333)** | **1,166** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Revaluations | 18 | 11,064 | 2,491 |
| **Total comprehensive (expense) / income for the year** | | **(13,269)** | **3,657** |
| **(Deficit) / Surplus for the period attributable to:** | | | |
| Torbay and South Devon NHS Foundation Trust | | (24,333) | 1,166 |
| **TOTAL** | | **(24,333)** | **1,166** |
| **Total comprehensive (expense) / income for the year attributable to:** | | | |
| Torbay and South Devon NHS Foundation Trust | | (13,269) | 3,657 |
| **TOTAL** | | **(13,269)** | **3,657** |

Torbay and South Devon NHS Foundation Trust

## Statement of Financial Position as at 31 March 2023

| | Notes | Group | | Trust | |
|---|---|---|---|---|---|
| | | 31 March 2023 | 31 March 2022 | 31 March 2023 | 31 March 2022 |
| | | £000 | £000 | £000 | £000 |
| **Non-current assets** | | | | | |
| Intangible assets | 14 | 16,604 | 11,864 | 16,604 | 11,864 |
| Property, plant and equipment | 15 & 16 | 254,235 | 239,427 | 254,126 | 239,297 |
| Right of use assets | 19 | 21,765 | 0 | 21,765 | 0 |
| Investments in associates (and joint ventures) | 20 | 0 | 0 | 0 | 0 |
| Receivables | 22 | 1,540 | 1,438 | 1,878 | 1,813 |
| **Total non-current assets** | | **294,144** | **252,729** | **294,373** | **252,974** |
| **Current assets** | | | | | |
| Inventories | 21 | 13,459 | 11,395 | 12,772 | 10,705 |
| Receivables | 22 | 39,141 | 27,397 | 39,030 | 27,249 |
| Non-current assets held for sale | 23 | 2,102 | 2,452 | 2,102 | 2,452 |
| Cash and cash equivalents | 24 | 34,734 | 39,342 | 34,645 | 39,008 |
| **Total current assets** | | **89,436** | **80,586** | **88,549** | **79,414** |
| **Current liabilities** | | | | | |
| Trade and other payables | 25 | (82,160) | (67,079) | (82,395) | (66,928) |
| Borrowings | 27 | (7,844) | (7,476) | (7,844) | (7,476) |
| Provisions | 29 | (450) | (467) | (450) | (467) |
| Other liabilities | 26 | (8,015) | (10,293) | (8,015) | (10,293) |
| **Total current liabilities** | | **(98,469)** | **(85,315)** | **(98,704)** | **(85,164)** |
| **Total assets less current liabilities** | | **285,111** | **248,000** | **284,218** | **247,224** |
| **Non-current liabilities** | | | | | |
| Borrowings | 27 | (54,583) | (48,338) | (54,583) | (48,338) |
| Provisions | 29 | (4,633) | (5,955) | (4,633) | (5,955) |
| **Total non-current liabilities** | | **(59,216)** | **(54,293)** | **(59,216)** | **(54,293)** |
| **Total assets employed** | | **225,895** | **193,707** | **225,002** | **192,931** |
| | | | | | |
| **Financed by** | | | | | |
| Public dividend capital | | 195,614 | 150,332 | 195,614 | 150,332 |
| Revaluation reserve | | 62,093 | 51,538 | 62,093 | 51,538 |
| Income and expenditure reserve | | (31,812) | (8,163) | (32,705) | (8,939) |
| **Total taxpayers' equity** | | **225,895** | **193,707** | **225,002** | **192,931** |

**The notes on pages 14 to 67 form part of these accounts**

**Signed** ……………………………………………

Name **Liz Davenport**

Position **Chief Executive**

Date **28th June 2023**

**Torbay and South Devon NHS Foundation Trust**

## Statement of Changes in Equity for the year ended 31 March 2023

| Group | Public dividend capital £000 | Revaluation reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | **150,332** | **51,538** | **(8,163)** | **193,707** |
| Impact of implementing IFRS 16 on 1st April 2022 | 0 | 0 | 175 | **175** |
| Deficit for the year | 0 | 0 | (24,333) | **(24,333)** |
| Revaluations - property plant and equipment | 0 | 11,054 | 0 | **11,054** |
| Revaluations - right of use assets | 0 | 10 | 0 | **10** |
| Transfer to retained earnings on disposal of assets | 0 | (509) | 509 | **0** |
| Public dividend capital received | 45,282 | 0 | 0 | **45,282** |
| **Taxpayers' and others' equity at 31 March 2023** | **195,614** | **62,093** | **(31,812)** | **225,895** |

## Statement of Changes in Equity for the year ended 31 March 2022

| Group | Public dividend capital £000 | Revaluation reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2021 - brought forward** | **130,755** | **49,152** | **(9,434)** | **170,473** |
| Surplus for the year | **0** | **0** | **1,166** | **1,166** |
| Revaluations - property plant and equipment | **0** | **2,491** | **0** | **2,491** |
| Transfer to retained earnings on disposal of assets | **0** | **(105)** | **105** | **0** |
| Public dividend capital received | **19,577** | **0** | **0** | **19,577** |
| **Taxpayers' and others' equity at 31 March 2022** | **150,332** | **51,538** | **(8,163)** | **193,707** |

## Statement of Changes in Equity for the year ended 31 March 2023

| Trust | Public dividend capital £000 | Revaluation reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | **150,332** | **51,538** | **(8,939)** | **192,931** |
| Impact of implementing IFRS 16 on 1st April 2022 | 0 | 0 | 175 | **175** |
| Deficit for the year | 0 | 0 | (24,450) | **(24,450)** |
| Revaluations - property plant and equipment | 0 | 11,054 | 0 | **11,054** |
| Revaluations - right of use assets | 0 | 10 | 0 | **10** |
| Transfer to retained earnings on disposal of assets | 0 | (509) | 509 | **0** |
| Public dividend capital received | 45,282 | 0 | 0 | **45,282** |
| **Taxpayers' and others' equity at 31 March 2023** | **195,614** | **62,093** | **(32,705)** | **225,002** |

## Statement of Changes in Equity for the year ended 31 March 2022

| Trust | Public dividend capital £000 | Revaluation reserve £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | **130,755** | **49,152** | **(10,097)** | **169,810** |
| Surplus for the year | 0 | 0 | 1,053 | **1,053** |
| Revaluations - property plant and equipment | 0 | 2,491 | 0 | **2,491** |
| Transfer to retained earnings on disposal of assets | 0 | (105) | 105 | **0** |
| Public dividend capital received | 19,577 | 0 | 0 | **19,577** |
| **Taxpayers' and others' equity at 31 March 2022** | **150,332** | **51,538** | **(8,939)** | **192,931** |

**Torbay and South Devon NHS Foundation Trust**

## Information on reserves

### Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

### Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

### Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

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**Torbay and South Devon NHS Foundation Trust**

# Statement of Cash Flows

| | Note | Group | | Trust | |
|---|---|---|---|---|---|
| | | Year ended 2022/23 | Year Ended 2021/22 | Year Ended 2022/23 | Year ended 2021/22 |
| | | £000 | £000 | £000 | £000 |
| **Cash flows from operating activities** | | | | | |
| Operating surplus / (deficit) | | (16,035) | 9,253 | (16,196) | 9,094 |
| **Non-cash income and expense:** | | | | | |
| Depreciation and amortisation | 5 | 18,956 | 17,326 | 18,935 | 17,306 |
| Net impairments | 6.1 | 9,109 | (863) | 9,109 | (863) |
| Income recognised in respect of capital donations | | (2,181) | (299) | (2,181) | (299) |
| (Increase) / Decrease in receivables and other assets | | (12,600) | (5,288) | (12,637) | (5,316) |
| Decrease / (Increase) in inventories | | (2,064) | 565 | (2,067) | 604 |
| Increase in payables and other liabilities | | 13,348 | 4,997 | 13,726 | 4,985 |
| (Decrease) / Increase in provisions | | (1,428) | (22) | (1,428) | (22) |
| Tax paid | | (30) | (19) | 0 | 0 |
| **Net cash flows from operating activities** | | **7,075** | **25,650** | **7,261** | **25,489** |
| **Cash flows from investing activities** | | | | | |
| Interest received | | 664 | 19 | 686 | 43 |
| Proceeds from sales of financial assets | | 68 | 0 | 68 | 0 |
| Purchase of intangible assets | | (7,865) | (3,164) | (7,865) | (3,164) |
| Purchase of Property, Plant and Equipment | | (35,569) | (31,849) | (35,569) | (31,849) |
| Sales of Property, Plant and Equipment | | 0 | 8 | 0 | 8 |
| Receipt of cash donations to purchase assets | | 2,181 | 252 | 2,181 | 252 |
| Finance lease receipts (principal and interest) | | 59 | 0 | 59 | 0 |
| **Net cash flows used in investing activities** | | **(40,462)** | **(34,734)** | **(40,440)** | **(34,710)** |
| **Cash flows from financing activities** | | | | | |
| Public dividend capital received | | 45,282 | 19,577 | 45,282 | 19,577 |
| Movement on loans from DHSC | | (3,867) | (4,805) | (3,867) | (4,805) |
| Other capital receipts * | | 0 | 0 | 37 | 36 |
| Capital element of finance lease rental payments | | (3,292) | (1,964) | (3,292) | (1,964) |
| Capital element of PFI obligations | | (1,312) | (1,166) | (1,312) | (1,166) |
| Interest paid on loans | | (706) | (833) | (706) | (833) |
| Interest paid on finance leases liabilities | | (398) | (415) | (398) | (415) |
| Interest paid on PFI obligations | | (1,847) | (1,753) | (1,847) | (1,753) |
| PDC dividend paid | | (5,081) | (5,660) | (5,081) | (5,660) |
| **Net cash flows from financing activities** | | **28,779** | **2,981** | **28,816** | **3,017** |
| **Decrease in cash and cash equivalents** | | **(4,608)** | **(6,103)** | **(4,363)** | **(6,204)** |
| **Cash and cash equivalents at 1 April - brought forward** | | **39,342** | **45,445** | **39,008** | **45,212** |
| **Cash and cash equivalents at 31 March** | 24 | **34,734** | **39,342** | **34,645** | **39,008** |

* Other Capital Receipts for the Trust totalling £37,000 (2021/22 £36k) represents the value of loan principal repayment received from the Trust's wholly owned subsidiary company, SDH Developments Ltd

# Torbay and South Devon NHS Foundation Trust

## Notes to the Accounts

## Note 1 Accounting policies and other information

### Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

### Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

### Note 1.2 Critical judgements and sources of Estimation uncertainty in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision and future periods if the revision affects both current and future periods.

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

**Modern equivalent asset valuation of property - key sources of estimation uncertainty**

As detailed in accounting policy note 1.11.2 'Property, plant and equipment - valuation', the Trust has applied a Modern Equivalent Asset approach to valuing its Land and specialised buildings and buildings excluding dwellings. The significant estimate being depreciated replacement value, using modern equivalent methodology - both on an alternative site basis and construction methodology. The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 18 to the financial statements. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

### Note 1.2 Critical judgements and sources of Estimation uncertainty in applying accounting policies (continued)

**Impairments and the estimated lives of assets - key sources of estimation uncertainty**

As detailed in accounting policy notes 1.11.2 and 1.12.2, 'Property, Plant and Equipment - Measurement' and 'Intangibles - Measurement', the Trust is required to review property, plant and equipment and intangibles for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors (property, plant and equipment - buildings and buildings excluding dwellings), management make judgements about the condition of assets and review their estimated lives. The Trust has been notified that it will benefit from the Government's 'New Hospial Programme'. Business cases to support this potential investment are currently being developed. If successful, potentially a significant part of the Trust's Buildings excluding Dwellings, as well as the Dwellings themselves will be replaced over the next decade. No provision for impairment of these assets has yet to take place due to two principal factors. The first being that the design of the new facility is not yet finalised and the second factor is that the financial support for such investment is still subject to business cases being approved by NHSE, the Deaprtment of Health and HM Treasury. The Trust will keep this area of financial asessment under constant review.

**Provision for expected credit loss of contract receivables - critical accounting judgement**

Management will use their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect debt. There are significant judgements in recognition of revenue from care of patients and clients and in provisioning for disputes with commissioners, clients and customers.

**Provisions - critical accounting judgement**

Management will use their judgement to decide when to make provisions for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The carrying amounts to the Trust's provisions are detailed in note 29 to the financial statements.

### Note 1.3 Consolidation

**Subsidiary**

The Group financial statements consolidate the financial statements of the Trust and its subsidiary undertaking made up to 31 March 2023.
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. In accordance with the NHS Foundation Trust Annual Reporting Manual a separate income statement for the parent (the Trust) has not been prepared.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.
Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust is the Corporate Trustee of Torbay South Devon NHS Charitable Fund (Registered Charity 1052232). Under International Accounting Standards the Charitable Fund is considered to be a subsidiary of the Trust. The financial results of the Charity have not been consolidated into the Trust's Financial Statements. The reason for not consolidating is that it is not thought to be helpful to reader of the Trust accounts and the Trust has elected not to consolidate on the grounds of immateriality.

### Note 1.3 Consolidation (continued)

**Joint ventures**
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

**Joint Operations**
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

### Note 1.4 Segmental Reporting

During 2022/23 and 2021/22 the Trust did not report its expenditure to the Trust Board using a segmental reporting analysis and therefore representing the data is not possible.

### Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust’s entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

***Revenue from NHS contracts***

The main source of income for the Trust is contracts with commissioners for health care services. In 2022/23, the majority of the trust’s income from NHS commissioners was in the form of block contract arrangements.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2022/23, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

***Revenue from research contracts***

Where research contracts fall under IFRS15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust’s interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.  Some research income alternatively falls within the provisions of IAS 20 for government grants.

### Note 1.5 Revenue from contracts with customers (continued)

***Revenue from Education and training (excluding notional apprenticeship levy income)***

Torbay and South Devon NHS Foundation Trust

The Trust receives income through contracts with Commissioners to deliver Education and Training services to its staff. The Trust recognises the income when performance obligations are satisfied. The income is recognised in line contract values.

***NHS injury cost recovery scheme***

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means treatment has been given when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

## Note 1.6 Other forms of income

***Grants and donations***

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

***Apprenticeship service income***

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## Note 1.7 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

## Note 1.8 Expenditure on employee benefits

**Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

*NHS Pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Scheme. Both schemes are unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period, The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

**Torbay and South Devon NHS Foundation Trust**

### Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### Note 1.10 Discontinued Operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

### Note 1.11 Property, plant and equipment

#### Note 1.11.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control or form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, then these components are treated as separate assets and depreciated over their own useful lives.

***Subsequent expenditure***

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

#### Note 1.11.2 Measurement

***Valuation***

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

#### Note 1.11.2 Measurement (continued)

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.
Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) schemes where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Valuations of the Land and non specialised buildings and specialised buildings are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The latest full revaluation of the Trust's specialised building was undertaken in 2018/19 with a prospective valuation date of 31 March 2019. Full physical valuations take place every 5 years.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

***Depreciation***
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

***Revaluation gains and losses***
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expense.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

***Impairments***
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

**Note 1.11.3 De-recognition**

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### Note 1.11.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2021/22 this included receipt of assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

### Note 1.11.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

### Note 1.11.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are

| | Min life Years | Max life Years |
|---|---:|---:|
| Land | - | - |
| Buildings, excluding dwellings | 6 | 70 |
| Dwellings | 36 | 48 |
| Plant & machinery | 2 | 25 |
| Transport equipment | 3 | 7 |
| Information technology | 2 | 15 |
| Furniture & fittings | 2 | 10 |

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term,

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## Note 1.12 Intangible assets

### Note 1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

***Internally generated intangible assets***
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised only where it meets the requirements set out IAS 38.

***Software***
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

### Note 1.12.2 Measurement

Intangible assets are recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner for operational use. They are subsequently valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

***Amortisation***
The Trust has two classes of Intangible assets, namely software licences and registered licences to manufacture Pharmaceutical licences. Both are assessed to have finite lives and these are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

### Note 1.12.3 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

| | Min life<br>Years | Max life<br>Years |
|---|---|---|
| Software licences | 3 | 13 |
| Licences & trademarks | 2 | 10 |

## Note 1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust has a number of separate stock control systems and consequently cost of inventories is measured by either using on a first in, first out (FIFO) method or the weighted average cost method.

In 2022/23, the Trust continued to receive inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Work in progress comprises goods in intermediate stages of production.

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### Note 1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

### Note 1.15 Financial assets and financial liabilities

***Recognition***

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

**Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost,

Financial liabilities classified as subsequently measured at amortised cost.

***Financial assets and financial liabilities at amortised cost***

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

***Impairment of financial assets***

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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### Note 1.15 Financial instruments and financial liabilities (continued)

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust undertakes a regular review of its aged debt analysis to ensure that invoices are settled in a prompt manner and to ensure that any debts that show signs of being disputed are escalated appropriately. If as a consequence of an investigation the likelihood of debt recovery is remote, a provision for a potential credit loss is made. A provision for a credit loss for is applied to NHS Recovery Unit debts as advised by NHSI. The Trust also applies a provision for expected credit losses against its Adult Social Care debtors.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected credit losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

***De-recognition***

Financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### Note 1.16 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

### Note 1.16.1 The trust as lessee

*Recognition and initial measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

**Note 1.16 Leases (continued)**

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

**The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the head lease.

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

*Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

**Note 1.16 Leases (continued)**

**Initial application of IFRS 16**

*IFRS 16 Leases* as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

*The Trust as lessee*

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

*The Trust as lessor*

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

*2021/22 comparatives*

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

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## Note 1.17 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2023.

| | | Nominal rate | Prior year rate |
|---|---|---|---|
| Short-term | Up to 5 years | 3.27% | 0.47% |
| Medium-term | After 5 years up to 10 years | 3.20% | 0.70% |
| Long-term | After 10 years up to 40 years | 3.51% | 0.95% |

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2023:

| | Inflation rate | Prior year rate |
|---|---|---|
| Year 1 | 7.40% | 4.00% |
| Year 2 | 0.60% | 2.60% |
| Into perpetuity | 2.00% | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 1.1%)

***Clinical negligence costs***

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 30 but is not recognised in the trust’s accounts.

***Non-clinical risk pooling***

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

## Note 1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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### Note 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for: -

* Donated and Granted assets

* Average daily cash balances / deposits held with the Government Banking Service / National Loan Funds
* Approved expenditure on COVID-19 assets
* Assets under construction for nationally directed schemes.
* Approved expenditure on COVID-19 assets

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### Note 1.20 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### Note 1.21 Corporation tax

The Trust is a Health Service Body within the meaning of s986 Corporation Taxes Act 2010. Accordingly it is not liable to corporation tax. The Trust is also exempt from tax on chargeable gains under S271(3) of Chargeable Gains Act 1992.
There is however a power of HM Treasury to submit an order to Parliament, which will dis-apply the corporation tax emption in relation to particular activities of a NHS Foundation Trust (s987 Corporation Taxes Act 2010). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities to be specified in the order which are not related to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the order is approved by Parliament, the trust has no corporation tax liability.

The Trust's subsidiary company profit and losses are subject to Corporation tax, the costs and liability for which are disclosed in the Trust's consolidated financial statements.

### Note 1.22 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

### Note 1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, where held, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

### Note 1.24 Losses and special payment

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Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

### Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

### Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

### Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

**IFRS 16 Leases - application of liability measurement principles to PFI and other service concession arrangements**

From 1 April 2023, the measurement principles of IFRS 16 will also be applied to the Trust’s PFI liabilities where future payments are linked to [a price index representing the rate of inflation]. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. The effect of this has not yet been quantified.

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## Note 2 Operating Segments

### Note 2.1 Operating Segments 2022/23 and 2021/22 (Group)

The Trust's Chief Operating Decision maker is the Board of Directors.
The Board of Directors functions as a corporate decision-making body. Executive Director and Non-executive Director are full and equal members. Their role as members of the Board of Directors is to consider the key strategic and governance issues facing the Trust in carrying out its statutory and other functions

In line with IFRS 8 'Operating Segments', the Trust uses three key factors in its identification of its reportable operating segments. The factors are that the reportable operating segment: -

* engages in activities from which it earns revenues and incurs expenses
* reports financial results which are regularly reviewed by the Trust's board of directors to make decisions about allocation of resources to the segment and assess its performance
* has discrete financial information.

The Trust Board received financial information on its operation as a whole. Budgeting and investment decisions are also considered at a whole 'system' level (i.e. the impact is considered at both Trust wide and Commissioner level). Investment decisions are not purely financially driven and the complexity of the information provided to the Trust Board to support the decision making will vary depending upon the nature and scale of the investments being proposed. Accordingly the information received by the Trust Board during 2022/23 is in accordance with these financial accounts.

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### Note 3 Operating income from patient care activities, by nature. (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| **Acute services** | | |
| Income from commissioners | 340,288 | 315,030 |
| High cost drugs income from commissioners | 28,596 | 22,935 |
| Other NHS clinical income | 2,782 | 8,909 |
| **Community services** | | |
| Block contract / system envelope income | 102,847 | 106,311 |
| Income from other sources (e.g. local authorities) | 78,446 | 73,476 |
| **All trusts** | | |
| Private patient income | 978 | 633 |
| Elective recovery fund | 5,138 | 3,744 |
| Agenda for change pay offer central funding * | 12,079 | - |
| Additional pension contribution central funding ** | 12,985 | 12,199 |
| Other clinical income** | 496 | 443 |
| **Total income from patient care activities** | **584,635** | **543,680** |

***T**his central funding relates to the estimated cost impact of the Substantive non consolidated pay offer to NHS employees in respect of the financial year 2022/23. This offer is still being discussed by National staffside and National NHS Management and therefore had not been cash transacted as at 31st March 2023. A contract receivable and an accrual for this value are included in Note 22. Receivables and 25. Payables as at 31st March 2023

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administrative charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts

### Note 3.1 Income from patient care activities, by source (Group)

| | 2022/23 | 2021/22 |
|---|---|---|
| **Income from patient care activities received from:** | £000 | £000 |
| NHS England | 80,760 | 57,149 |
| Clinical commissioning groups | 99,127 | 410,416 |
| Integrated Care Boards | 322,507 | 0 |
| NHS Trusts | 2,425 | 2,112 |
| Local authorities | 64,166 | 60,234 |
| Non-NHS: private patients | 880 | 633 |
| Non-NHS: overseas patients (chargeable to patient) | 94 | 45 |
| NHS injury scheme * | 478 | 346 |
| Non NHS: other ** | 14,198 | 12,745 |
| **Total income from activities** | **584,635** | **543,680** |
| **Of which:** | | |
| Related to continuing operations | 584,635 | 543,680 |
| Related to discontinued operations | 0 | 0 |

* NHS Injury Scheme Income is subject to a provision for doubtful debts of 23.76% to reflect expected rates of collection

** Non NHS Other Income is comprised mostly of Adult Social Care Client Contributions; Adult Social Care costs being means tested.

## Torbay and South Devon NHS Foundation Trust

### Note 3.2 Overseas visitors (relating to patients charged directly by the provider) (Group)

| | 2022/23 £000 | 2021/22 £000 |
|---|---|---|
| Income recognised this year | 94 | 45 |
| Cash payments received in-year | 47 | 27 |
| Amounts added to provision for impairment of receivables | 0 | 0 |
| Amounts written off in-year | 68 | 5 |

### Note 4 Other operating income (Group)

| | 2022/23 | | | 2021/22 | | |
|---|---|---|---|---|---|---|
| | Contract income £000 | Non-contract income £000 | Total £000 | Contract income £000 | Non-contract income £000 | Total £000 |
| Research and development (contract) | 1,845 | - | 1,845 | 3,024 | - | 3,024 |
| Education and training (excluding notional apprenticeship levy income) | 13,156 | - | 13,156 | 11,705 | - | 11,705 |
| Non-patient care services to other bodies | 8,190 | - | 8,190 | 8,358 | - | 8,358 |
| Reimbursement and top up funding | 1,127 | - | 1,127 | 3,763 | - | 3,763 |
| Other income (recognised in accordance with IFRS15) * | 30,236 | - | 30,236 | 27,446 | - | 27,446 |
| Education and training - notional income from apprenticeship fund | - | 970 | 970 | - | 989 | 989 |
| Donations of physical assets (non cash) | - | 0 | 0 | - | 0 | 0 |
| Donated equipment from DHSC for COVID response (non-cash) | - | 0 | 0 | - | 47 | 47 |
| Cash donations for the purchase of capital assets - received from NHS charities | - | 1,694 | 1,694 | - | 252 | 252 |
| Cash grants for the purchase of capital assets - received from other bodies | - | 487 | 487 | - | - | 0 |
| Charitable and other contributions to expenditure - received from other bodies | - | 347 | 347 | - | 399 | 399 |
| Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold | - | 0 | 0 | - | 253 | 253 |
| Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response | - | 587 | 587 | - | 851 | 851 |
| Rental revenue from operating leases | - | 798 | 798 | - | 773 | 773 |
| **Total other operating income** | **54,554** | **4,883** | **59,437** | **54,296** | **3,564** | **57,860** |
| **Of which:** | | | | | | |
| Related to continuing operations | | | 59,437 | | | 57,860 |
| Related to discontinued operations | | | 0 | | | 0 |

* Other income (recognised in accordance with IFRS 15) includes £20.9m of sales (2021/22 £21.6m) from the Trust's Pharmacy Manufacturing Unit. Other income (recognised in accordance with IFRS 15) also includes £1.6m (2021/22 £1.4m) from hosting the Audit South West - Internal Audit Counter Fraud and Consultancy Services

## Torbay and South Devon NHS Foundation Trust

### Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period (Group)

| | 2022/23<br>£000 | 2021/22<br>£000 |
|---|---|---|
| Revenue recognised in the reporting period that was included within contract liabilities at the end of the previous period | 9,915 | 7,417 |
| Revenue recognised from performance obligations satisfied (or partially satisfied in previous periods) | 0 | 0 |

### Note 4.2 Transaction price allocated to remaining performance obligations (Group)

| | 31 March 2023<br>£000 | 31st March 2021<br>£000 |
|---|---|---|
| Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised: | | |
| within one year | 8,015 | 10,293 |
| after one year, not later than five years | 0 | 0 |
| after five years | 0 | 0 |
| | **8,015** | **10,293** |

### Note 4.3 Income from activities arising from commissioner requested services (Group)

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

| | 2022/23<br>£000 | 2021/22<br>£000 |
|---|---|---|
| Income from services designated as commissioner requested services | 552,959 | 526,661 |
| Income from services not designated as commissioner requested services | 31,676 | 17,019 |
| **Total** | **584,635** | **543,680** |

### Note 4.4 Profits and losses on disposal of property, plant and equipment (Group)

During 2022/23 the Trust disposed of a number of Property, Plant and Equipment items and Intangible assets, the net loss of which was £138,000 (2021/22 net loss of £639,000). During 2021/22 £551,000 of the net loss of £639,000 related to items of medical equipment that were originally donated to the Trust by the NHS to assist the pandemic response, which were not required and were returned during 2021/22, no further losses have been occurred against these donations during 2022/23.

**Torbay and South Devon NHS Foundation Trust**

**Note 5 Operating expenses (Group)**

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from NHS and DHSC bodies | 19,628 | 17,377 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 57,530 | 47,859 |
| Purchase of social care | 78,690 | 72,468 |
| Staff and executive directors costs | 329,503 | 293,570 |
| Remuneration of non-executive directors | 187 | 174 |
| Supplies and services – clinical (excluding drugs costs) | 35,252 | 36,030 |
| Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response | 582 | 1,315 |
| Supplies and services - general | 5,850 | 5,269 |
| Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold | 0 | 253 |
| Drugs costs (drugs inventory consumed and purchase of non-inventory drugs) | 42,116 | 37,109 |
| Inventories written down | 93 | 121 |
| Consultancy | 936 | 362 |
| Establishment | 3,098 | 3,181 |
| Premises | 22,876 | 20,410 |
| Transport (including patient travel) | 3,626 | 3,026 |
| Depreciation on property, plant and equipment | 16,690 | 15,035 |
| Amortisation on intangible assets | 2,266 | 2,291 |
| Net impairments | 9,109 | (863) |
| Movement in credit loss allowance: contract receivables/assets | 1,213 | 777 |
| Increase/(decrease) in other provisions | 128 | 166 |
| Change in provisions discount rates | (1,099) | 162 |
| Audit fees payable to the external auditor: | | |
| audit services- statutory audit * | 176 | 136 |
| Internal audit costs** | 335 | 320 |
| Clinical negligence | 8,368 | 8,358 |
| Legal fees | 246 | 465 |
| Insurance | 57 | 65 |
| Research and development - staff costs | 1,975 | 1,812 |
| Research and development - non-staff | 41 | 83 |
| Education and training - staff costs | 11,557 | 10,159 |
| Education and training - non-staff | 2,084 | 1,809 |
| Education and training - notional expenditure funded from apprenticeship fund | 970 | 989 |
| Lease expenditure - short term leases (<=12 months) | 20 | 0 |
| Lease expenditure - low value assets (<=12 months) | 170 | 0 |
| Rentals under operating leases | 0 | 1,367 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI) | 1,338 | 1,254 |
| Grossing up consortium arrangements | 1,235 | 1,176 |
| Other | 3,261 | 8,202 |
| **Total** | **660,107** | **592,287** |
| **Of which:** | | |
| Related to continuing operations | 660,107 | 592,287 |
| Related to discontinued operations | 0 | 0 |

*** External Audit Fees.** The costs reported above relates to two elements, the first being the audit of the Trust and Group reported position. Grant Thornton LLP are responsible for this element of the service. The fee for 2022/23 was £150k (2021/22 £119k), VAT being irrecoverable. The audit fee disclosed above for 2022/23 also incorporates an additional fee totalling £9k for extra audit works undertaken in 2021/22 to validate the PPE valuations. The audit of the subsidiary is now being undertaken by Bishop Fleming LLP, whereas in 2021/22 the audit of the subsidiary was undertaken by Grant Thornton LLP. The fees charged for the subsidiary's audit was £17k (2021/22, £17k) VAT being recoverable.

**** Internal Audit costs.** The costs reported above represent the pay costs of the Internal Audit and Counter Fraud services the Trust has received the benefit of during the financial years. The Trust is part of a Peninsular wide Internal Audit and Counter Fraud consortium, where resources are shared with other and recharged to other NHS organisations. For accounting purposes, Torbay and South Devon NHS Foundation Trust operates as the lead consortium member. The Trust employs a proportion of the Audit and Counter Fraud consortiums staff. The value of charges made to the Trust by other organisations is shown as a 'Grossing up consortium arrangements' cost in operating expenditure and the value of charges made by the Trust as Lead Consortium member is recorded on 'Other income' within Other Operating Income.

# Torbay and South Devon NHS Foundation Trust

## Note 5.1 Other auditor remuneration (Group)

| | 2022/23 £000 | 2021/22 £000 |
|---|---|---|
| **Other auditor remuneration paid to the external auditor:** | | |
| Audit-related assurance services | 0 | 0 |
| **Total** | **0** | **0** |

No non-statutory fees were paid to the Trust's auditors during 2022/23 (2021/22 £0k). The Trust's external auditor was during 2021/22 also engaged to provide statutory audit services for Torbay and South Devon NHS Charitable Fund, for which the Trust is the Corporate Trustee (see also note 37.3). The Trust's external auditor resigned from this appointment in May 2022. Bishop Fleming LLP have since been appointed as the external auditor of Torbay and South Devon NHS Charitable Fund.

## Note 5.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2020/21: £2m).

## Note 6 Net impairments (Group)

## Note 6.1 Net Impairments total (Group)

| | Note | 2022/23 £000 | 2021/22 £000 |
|---|---|---|---|
| **Net impairments charged / (credited) to operating surplus / (deficit) surplus resulting from:** | | | |
| Loss or damage from normal operations | 6.2 | 44 | 276 |
| Abandonment of assets in the course of construction | 6.3 | 646 | 0 |
| Changes in market price | 6.4 | 8,419 | (1,139) |
| **Total net impairments credited to operating surplus** | | **9,109** | **(863)** |

## Note 6.2 Loss or damage from normal operations (Group)

During 2022/23 impairments from 'Loss or damage from normal operations' totalled £44k, (2021/22 £276k) . The impairment processed in 2022/23 related to one asset (2021/22, one asset). Both impairments related to the removal of modular structures to facilitate the construction of new facilities.

## Note 6.3 Abandonment of assets in the course of construction (Group)

Abandonment of assets in the course of construction totalling £646k during 2020/21 related to five construction projects totalling £633k and one item of Plant & Machinery totalling £13k. Four of the construction projects were abandoned after commissioning feasibility studies, the output of which indicated that future completion costs did not represent value for money and the one remaining construction project has been impaired due to uncertainty of the financial viability of the project. The one item of Plant and Equipment was impaired as it was no longer fit for purpose. No abandonment of assets in the course of construction took place during 2021/22

## Torbay and South Devon NHS Foundation Trust

### Note 6.4 Changes to market price (Group)

| | 2022/23 £000 | 2021/22 £000 |
|---|---|---|
| **Net impairments (credited) / charged to operating surplus resulting from:** | | |
| Revaluation of Trust's Buildings and Dwelling assets | 8,574 | (867) |
| Revaluation of Land | (155) | (272) |
| | **8,419** | **(1,139)** |

The Trust commissioned the District Valuation Office in both 2022/23 and 2021/22 to provide an updated valuation of the Trust's properties as at 31st March 2023 and 31st March 2022 respectively. The valuation exercises consisted of desktop reviews and also application of BCIS and local indexation factors. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but available for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value. The review increased the value of PPE Land, Buildings and Buildings excluding Dwellings by a net £2,645k (2021/22, £3,630k). Of the increase in value, £11,064k (2021/22, £2,491k) has been credited to the Trust's revaluation reserve and a net £8,419k has been charged (2021/22 credited, £1,139k) to Operating Expenditure as an Impairment credit/charge.

### Note 7 Employee benefits (Group)

| | 2022/23 Total £000 | 2021/22 Total £000 |
|---|---|---|
| Salaries and wages | 263,711 | 232,433 |
| Social security costs | 24,679 | 21,588 |
| Apprenticeship levy | 1,208 | 1,125 |
| Employer's contributions to NHS Pension scheme | 29,588 | 27,827 |
| Employer's contributions paid by NHSE on provider's behalf to NHS Pension scheme | 12,985 | 12,199 |
| Pension cost - other | 59 | 50 |
| Temporary staff (including agency) | 14,513 | 13,247 |
| **Total gross staff costs** | **346,743** | **308,469** |
| Costs capitalised as part of assets | 3,373 | 2,608 |

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administrative charge) from 1 April 2019. From 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts

### Note 7.1 Retirements due to ill-health (Group)

During 2022/23 there were 5 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £376k (£85k in 2021/22).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension scheme.

**Torbay and South Devon NHS Foundation Trust**

## Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

## Torbay and South Devon NHS Foundation Trust

### Note 9 Operating leases (Group)

### Note 9.1 Torbay and South Devon NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Torbay and South Devon NHS Foundation Trust is the lessor. Comparative disclosures in this note are presented on an IAS17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS17 compared to IFRS 16.

| | 2022/23 £000 | 2021/22 £000 |
|---|---|---|
| **Operating lease revenue** | | |
| Minimum lease receipts | 798 | 773 |
| **Total** | **798** | **773** |

| **Future minimum lease receipts due at 31 March 2023** | 2023 £000 |
|---|---|
| - not later than one year; | 671 |
| - later than one year and not later than two years; | 671 |
| - later than two years and not later than three years; | 671 |
| - later than three years and not later than four years; | 671 |
| - later than four years and not later than five years; | 671 |
| - later than five years; | 1,342 |
| | **4,697** |

| | 31 March 2022 £000 |
|---|---|
| **Future minimum lease receipts due at 31 March 2022** | |
| - not later than one year; | 650 |
| - later than one year and not later than five years; | 2,600 |
| - later than five years. | 1,950 |
| **Total** | **5,200** |

The Trust has a lease agreement with Devon Partnership Trust (DPT) which was extended for a period of 10 years from 1st April 2020. In 2022/23 this income totalled £798,000 (2021/22 £773,000). The lease income received in year and future minimum lease receipts due all relate to lease of buildings.

### Note 9.2 Torbay and South Devon NHS Foundation Trust as a lessee at 31st March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31st March 2022 for leases the trust previously determined to be operating leases under IAS 17

| | 2021/22 £000 |
|---|---|
| **Operating lease expense** | |
| Minimum lease payments | 1,268 |
| Contingent rents | 99 |
| **Total** | **1,367** |

| | 31 March 2022 £000 |
|---|---|
| **Future minimum lease payments due:** | |
| - not later than one year; | 1,264 |
| - later than one year and not later than five years; | 4,191 |
| - later than five years. | 5,068 |
| **Total** | **10,523** |
| Future minimum lease payments to be received * | 10,523 |

* - Included in these commitments was £3.6m for Regent House, a building in Regent Close, Torquay, where an extension to the existing lease has been agreed with the landlord for a period of 10 years (rent review due in 5 years). The Trust has also entered into a new 25 year lease for part of Sherborne House, a building in Newton Abbot. The total sum of commitments for this facility totals £3.8m with rent being inflated by RPI each year.

## Torbay and South Devon NHS Foundation Trust

### Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 664 | 19 |
| Interest income on finance leases | 59 | 0 |
| **Total** | **723** | **19** |

### Note 11 Finance expenses (Group)

Finance expenses represents interest and other charges involved in the borrowing of money or asset financing

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Loans from the Department of Health and Social Care | 686 | 814 |
| Finance leases | 404 | 399 |
| Main finance costs on PFI schemes obligations | 999 | 1,091 |
| Contingent finance costs on PFI schemes obligations | 848 | 662 |
| **Total interest expense** | **2,937** | **2,966** |
| Unwinding of discount on provisions | 89 | (70) |
| Other finance costs | | |
| **Total finance costs** | **3,026** | **2,896** |

### Note 11.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| Total liability accruing in year under this legislation as a result of late payments | 0 | 0 |
| Amounts included within interest payable arising from claims made under this legislation | 0 | 0 |
| Compensation paid to cover debt recovery costs under this legislation | 0 | 0 |

### Note 12 Other losses, net (Group)

| | 2022/23 | 2021/22 |
|---|---|---|
| | £000 | £000 |
| Gains on disposal of assets | 3 | 4 |
| Losses on disposal of assets | (141) | (643) |
| **Total losses, net on disposal of assets** | **(138)** | **(639)** |

### Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust’s deficit for the period was £(24,333)k; (2021/22 surplus of £1,053k). The trust's total comprehensive deficit for the period was £(13,279)k; (2021/22 income of £3,544k).

**Torbay and South Devon NHS Foundation Trust**

## Note 14 Intangible assets - Group and Trust

### Note 14.1 Intangible assets - 2022/23

| Group and Trust | Software licences £000 | Licences & trademarks £000 | Development expenditure £000 | Intangible assets under construction £000 | Total £000 |
|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2022 - brought forward** | **15,612** | **1,706** | **0** | **5,674** | **22,992** |
| Reclassification of existing finance leased assets to right of use assets on 1 April 2022 | (40) | 0 | 0 | 0 | **(40)** |
| Additions | 458 | 10 | 0 | 7,018 | **7,486** |
| Impairments | 0 | 0 | 0 | 0 | **0** |
| Reclassifications | 2,195 | 389 | 0 | (2,993) | **(409)** |
| Disposals / derecognition | (583) | (19) | 0 | 0 | **(602)** |
| **Valuation / gross cost at 31 March 2023** | **17,642** | **2,086** | **0** | **9,699** | **29,427** |
| **Accumulated Amortisation at 1 April 2022 - brought forward** | **11,128** | **0** | **0** | **0** | **11,128** |
| Reclassification of existing finance leased assets to right of use assets on 1 April 2022 | (4) | 0 | 0 | 0 | **(4)** |
| Provided during the year | 2,170 | 90 | 0 | 0 | **2,260** |
| Reclassifications | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | (559) | (2) | 0 | 0 | **(561)** |
| **Accumulated Amortisation at 31 March 2023** | **12,735** | **88** | **0** | **0** | **12,823** |
| **Net book value at 31 March 2023** | **4,907** | **1,998** | **0** | **9,699** | **16,604** |
| **Net book value at 31 March 2022** | **4,484** | **1,706** | **0** | **5,674** | **11,864** |

### Note 14.2 Intangible assets - 2021/22

| Group and Trust | Software licences £000 | Licences & trademarks £000 | Development expenditure £000 | Intangible assets under construction £000 | Total £000 |
|---|---|---|---|---|---|
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | **16,158** | **1,037** | **0** | **3,598** | **20,793** |
| Additions | 539 | 5 | 0 | 3,933 | **4,477** |
| Impairments | 0 | 0 | 0 | 0 | **0** |
| Reclassifications | 240 | 664 | 0 | (1,857) | **(953)** |
| Disposals / derecognition | (1,325) | 0 | 0 | 0 | **(1,325)** |
| **Valuation / gross cost at 31 March 2023** | **15,612** | **1,706** | **0** | **5,674** | **22,992** |
| **Accumulated Amortisation at 1 April 2022 - brought forward** | **10,702** | **0** | **0** | **0** | **10,702** |
| Provided during the year | 2,291 | 0 | 0 | 0 | **2,291** |
| Reclassifications | (575) | 0 | 0 | 0 | **(575)** |
| Disposals / derecognition | (1,290) | 0 | 0 | 0 | **(1,290)** |
| **Accumulated Amortisation at 31 March 2023** | **11,128** | **0** | **0** | **0** | **11,128** |
| **Net book value at 31 March 2022** | **4,484** | **1,706** | **0** | **5,674** | **11,864** |
| **Net book value at 31 March 2021** | **5,456** | **1,037** | **0** | **3,598** | **10,091** |

# Torbay and South Devon NHS Foundation Trust

## Note 15 Property, plant and equipment - Group

### Note 15.1 Property, plant and equipment - 2022/23

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2022 - brought forward** | **7,960** | **157,484** | **4,306** | **39,219** | **63,994** | **1,374** | **23,353** | **424** | **298,114** |
| IFRS 16 implementation - reclassification to right of use assets | 0 | (561) | 0 | (663) | (6,317) | (685) | (5,222) | 0 | **(13,448)** |
| Additions | 0 | 10,447 | 53 | 23,789 | 544 | 39 | 200 | 339 | **35,411** |
| Impairments | 0 | (8,998) | 0 | 0 | (13) | 0 | 0 | 0 | **(9,011)** |
| Reversals of impairments | 155 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **155** |
| Revaluations | (40) | 4,354 | (142) | 0 | 0 | 0 | 0 | 0 | **4,172** |
| Reclassifications | 0 | 16,488 | 250 | (23,426) | 5,163 | 68 | 1,781 | 85 | **409** |
| Disposals / derecognition | 0 | (11) | 0 | 0 | (9,317) | (24) | (3,304) | (24) | **(12,680)** |
| **Valuation/gross cost at 31 March 2023** | **8,075** | **179,203** | **4,467** | **38,919** | **54,054** | **772** | **16,808** | **824** | **303,122** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2022 - brought forward** | **0** | **61** | **0** | **0** | **41,034** | **998** | **16,416** | **178** | **58,687** |
| IFRS 16 implementation - reclassification to right of use assets | 0 | 0 | 0 | 0 | (1,692) | (415) | (1,332) | 0 | **(3,439)** |
| Provided during the year | 0 | 6,687 | 247 | 0 | 4,769 | 26 | 1,302 | 70 | **13,101** |
| Revaluations | 0 | (6,635) | (247) | 0 | 0 | 0 | 0 | 0 | **(6,882)** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | (10) | 0 | 0 | (9,232) | (24) | (3,290) | (24) | **(12,580)** |
| **Accumulated depreciation at 31 March 2023** | **0** | **103** | **0** | **0** | **34,879** | **585** | **13,096** | **224** | **48,887** |
| | | | | | | | | | |
| **Net book value at 31 March 2023** | **8,075** | **179,100** | **4,467** | **38,919** | **19,175** | **187** | **3,712** | **600** | **254,235** |
| **Net book value at 31 March 2022** | **7,960** | **157,423** | **4,306** | **39,219** | **22,960** | **376** | **6,937** | **246** | **239,427** |

## Torbay and South Devon NHS Foundation Trust

### Note 15 Property, plant and equipment - Group

#### Note 15.2 Property, plant and equipment - 2021/22

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2021 - brought forward** | **9,273** | **153,927** | **4,204** | **23,523** | **59,078** | **1,377** | **21,455** | **4,852** | **277,689** |
| Additions | 0 | 1,268 | 12 | 31,327 | 863 | 29 | 17 | 45 | **33,561** |
| Impairments | 0 | (1,424) | 0 | 0 | 0 | 0 | 0 | 0 | **(1,424)** |
| Reversals of impairments | 272 | 2,015 | 0 | 0 | 0 | 0 | 0 | 0 | **2,287** |
| Revaluations | 115 | (4,557) | (210) | 0 | 0 | 0 | 0 | 0 | **(4,652)** |
| Reclassifications | 0 | 6,255 | 300 | (15,631) | 7,080 | 77 | 2,808 | 64 | **953** |
| Transfers to/ from assets held for sale | (1,700) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **(1,700)** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (3,027) | (109) | (927) | (4,537) | **(8,600)** |
| **Valuation/gross cost at 31 March 2022** | **7,960** | **157,484** | **4,306** | **39,219** | **63,994** | **1,374** | **23,353** | **424** | **298,114** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2021 - brought forward** | **0** | **35** | **0** | **0** | **37,474** | **974** | **15,058** | **4,667** | **58,208** |
| Provided during the year | 0 | 6,923 | 246 | 0 | 5,424 | 133 | 2,261 | 48 | **15,035** |
| Revaluations | 0 | (6,897) | (246) | 0 | 0 | 0 | 0 | 0 | **(7,143)** |
| Reclassifications | 0 | 0 | 0 | 0 | 575 | 0 | 0 | 0 | **575** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (2,439) | (109) | (903) | (4,537) | **(7,988)** |
| **Accumulated depreciation at 31 March 2022** | **0** | **61** | **0** | **0** | **41,034** | **998** | **16,416** | **178** | **58,687** |
| | | | | | | | | | |
| **Net book value at 31 March 2022** | **7,960** | **157,423** | **4,306** | **39,219** | **22,960** | **376** | **6,937** | **246** | **239,427** |
| **Net book value at 31 March 2021** | **9,273** | **153,892** | **4,204** | **23,523** | **21,604** | **403** | **6,397** | **185** | **219,481** |

## Torbay and South Devon NHS Foundation Trust

### Note 15.3 Property, plant and equipment financing - 2022/23

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2023** | | | | | | | | | |
| Owned - purchased | 8,075 | 152,650 | 4,467 | 37,491 | 17,165 | 154 | 3,668 | 543 | **224,213** |
| On-SoFP PFI contracts and other service concession arrangements | 0 | 20,313 | 0 | 0 | 0 | 0 | 0 | 0 | **20,313** |
| Owned - donated / granted | 0 | 6,137 | 0 | 1,428 | 1,484 | 33 | 44 | 57 | **9,183** |
| Owned - equipment donated from DHSC and NHSE for COVID response | 0 | 0 | 0 | 0 | 526 | 0 | 0 | 0 | **526** |
| **NBV total at 31 March 2023** | **8,075** | **179,100** | **4,467** | **38,919** | **19,175** | **187** | **3,712** | **600** | **254,235** |

### Note 15.4 Property, plant and equipment financing - 2021/22

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2022** | | | | | | | | | |
| Owned - purchased | 7,960 | 133,451 | 4,306 | 38,643 | 16,046 | 79 | 3,014 | 230 | **203,729** |
| Finance leased | 0 | 560 | 0 | 576 | 4,625 | 270 | 3,889 | 0 | **9,920** |
| On-SoFP PFI contracts and other service concession arrangements | 0 | 17,598 | 0 | 0 | 0 | 0 | 0 | 0 | **17,598** |
| Owned - donated / granted | 0 | 5,814 | 0 | 0 | 1,699 | 27 | 34 | 16 | **7,590** |
| Owned - equipment donated from DHSC and NHSE for COVID response | 0 | 0 | 0 | 0 | 590 | 0 | 0 | 0 | **590** |
| **NBV total at 31 March 2022** | **7,960** | **157,423** | **4,306** | **39,219** | **22,960** | **376** | **6,937** | **246** | **239,427** |

## Torbay and South Devon NHS Foundation Trust

### Note 16 Property, plant and equipment - Trust

### Note 16.1 Property, plant and equipment - 2022/23

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2022 - brought forward** | **7,960** | **157,484** | **4,306** | **39,219** | **63,786** | **1,374** | **23,353** | **424** | **297,906** |
| IFRS 16 implementation - reclassification to right of use assets | 0 | (561) | 0 | (663) | (6,317) | (685) | (5,222) | 0 | **(13,448)** |
| Additions | 0 | 10,447 | 53 | 23,789 | 544 | 39 | 200 | 339 | **35,411** |
| Impairments | 0 | (8,998) | 0 | 0 | (13) | 0 | 0 | 0 | **(9,011)** |
| Reversals of impairments | 155 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **155** |
| Revaluations | (40) | 4,354 | (142) | 0 | 0 | 0 | 0 | 0 | **4,172** |
| Reclassifications | 0 | 16,488 | 250 | (23,426) | 5,163 | 68 | 1,781 | 85 | **409** |
| Transfers to/ from assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | (11) | 0 | 0 | (9,317) | (24) | (3,304) | (24) | **(12,680)** |
| **Valuation/gross cost at 31 March 2023** | **8,075** | **179,203** | **4,467** | **38,919** | **53,846** | **772** | **16,808** | **824** | **302,914** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2022 - brought forward** | **0** | **61** | **0** | **0** | **40,956** | **998** | **16,416** | **178** | **58,609** |
| IFRS 16 implementation - reclassification to right of use assets | 0 | 0 | 0 | 0 | (1,692) | (415) | (1,332) | 0 | **(3,439)** |
| Provided during the year | 0 | 6,687 | 247 | 0 | 4,748 | 26 | 1,302 | 70 | **13,080** |
| Revaluations | 0 | (6,635) | (247) | 0 | 0 | 0 | 0 | 0 | **(6,882)** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Transfers to / from assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | (10) | 0 | 0 | (9,232) | (24) | (3,290) | (24) | **(12,580)** |
| **Accumulated depreciation at 31 March 2023** | **0** | **103** | **0** | **0** | **34,780** | **585** | **13,096** | **224** | **48,788** |
| | | | | | | | | | |
| **Net book value at 31 March 2023** | **8,075** | **179,100** | **4,467** | **38,919** | **19,066** | **187** | **3,712** | **600** | **254,126** |
| **Net book value at 31 March 2022** | **7,960** | **157,423** | **4,306** | **39,219** | **22,830** | **376** | **6,937** | **246** | **239,297** |

## Torbay and South Devon NHS Foundation Trust

### Note 16 Property, plant and equipment - Trust

#### Note 16.2 Property, plant and equipment - 2021/22

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2021 - brought forward** | 9,273 | 153,927 | 4,204 | 23,523 | 58,870 | 1,377 | 21,455 | 4,852 | 277,481 |
| Additions | 0 | 1,268 | 12 | 31,327 | 863 | 29 | 17 | 45 | 33,561 |
| Impairments | 0 | (1,424) | 0 | 0 | 0 | 0 | 0 | 0 | (1,424) |
| Reversals of impairments | 272 | 2,015 | 0 | 0 | 0 | 0 | 0 | 0 | 2,287 |
| Revaluations | 115 | (4,557) | (210) | 0 | 0 | 0 | 0 | 0 | (4,652) |
| Reclassifications | 0 | 6,255 | 300 | (15,631) | 7,080 | 77 | 2,808 | 64 | 953 |
| Transfers to/ from assets held for sale | (1,700) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,700) |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (3,027) | (109) | (927) | (4,537) | (8,600) |
| **Valuation/gross cost at 31 March 2022** | 7,960 | 157,484 | 4,306 | 39,219 | 63,786 | 1,374 | 23,353 | 424 | 297,906 |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2021 - brought forward** | 0 | 35 | 0 | 0 | 37,416 | 974 | 15,058 | 4,667 | 58,150 |
| Provided during the year | 0 | 6,923 | 246 | 0 | 5,404 | 133 | 2,261 | 48 | 15,015 |
| Revaluations | 0 | (6,897) | (246) | 0 | 0 | 0 | 0 | 0 | (7,143) |
| Reclassifications | 0 | 0 | 0 | 0 | 575 | 0 | 0 | 0 | 575 |
| Transfers to/ from assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (2,439) | (109) | (903) | (4,537) | (7,988) |
| **Accumulated depreciation at 31 March 2022** | 0 | 61 | 0 | 0 | 40,956 | 998 | 16,416 | 178 | 58,609 |
| | | | | | | | | | |
| **Net book value at 31 March 2022** | 7,960 | 157,423 | 4,306 | 39,219 | 22,830 | 376 | 6,937 | 246 | 239,297 |
| **Net book value at 31 March 2021** | 9,273 | 153,892 | 4,204 | 23,523 | 21,454 | 403 | 6,397 | 185 | 219,331 |

Torbay and South Devon NHS Foundation Trust

**Note 16.3 Property, plant and equipment financing - 2022/23**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2023** | | | | | | | | | |
| Owned - purchased | 8,075 | 152,650 | 4,467 | 37,491 | 17,056 | 154 | 3,668 | 543 | **224,104** |
| On-SoFP PFI contracts and other service concession arrangements | 0 | 20,313 | 0 | 0 | 0 | 0 | 0 | 0 | **20,313** |
| Owned - donated / granted | 0 | 6,137 | 0 | 1,428 | 1,484 | 33 | 44 | 57 | **9,183** |
| Owned - equipment donated from DHSC and NHSE for COVID response | 0 | 0 | 0 | 0 | 526 | 0 | 0 | 0 | **526** |
| **NBV total at 31 March 2023** | **8,075** | **179,100** | **4,467** | **38,919** | **19,066** | **187** | **3,712** | **600** | **254,126** |

**Note 16.4 Property, plant and equipment financing - 2021/22**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2022** | | | | | | | | | |
| Owned - purchased | 7,960 | 133,451 | 4,306 | 38,643 | 15,916 | 79 | 3,014 | 230 | **203,599** |
| Finance leased | 0 | 560 | 0 | 576 | 4,625 | 270 | 3,889 | 0 | **9,920** |
| On-SoFP PFI contracts and other service concession arrangements | 0 | 17,598 | 0 | 0 | 0 | 0 | 0 | 0 | **17,598** |
| Owned - donated / granted | 0 | 5,814 | 0 | 0 | 1,699 | 27 | 34 | 16 | **7,590** |
| Owned - equipment donated from DHSC and NHSE for COVID response | 0 | 0 | 0 | 0 | 590 | 0 | 0 | 0 | **590** |
| **NBV total at 31 March 2022** | **7,960** | **157,423** | **4,306** | **39,219** | **22,830** | **376** | **6,937** | **246** | **239,297** |

## Torbay and South Devon NHS Foundation Trust

### Note 17 Grants & Donations of property, plant and equipment and intangibles (Group)

The Trust has benefitted from the receipt of Granted and Charitable Donations of Property, Plant and Equipment during 2022/23 totalling £2,181k (2021/22 total of £252,000). The Granted element totalling £487k (2021/22 £0k) relates to a contribution received from the University of Plymouth to enhance the facilities used by Medical Students whilst based at the Trust. Part of the Charitable funded element received during 2022/23 totalling £1,694k relates to generous Donations pledged by Torbay Hospital League of Friends totalling £1,350k for equipping costs of enhanced CT equipment and medical equipment used in the fit out of the Trust's new Ambulatory Medical Unit. A further generous sum of £300k has been received in 2022/23 from the Brixham's Hospital League of Friends to enhance the facilities of the Brixham Community Hospital and this has facilitated the co-location of General Practitioners within the hospital. The balance of the generous donations totalling £44k (2021/22 £252K) has been received from Donors to fund other developments and equipment purchases

During 2021/22 the Trust also benefited from the receipt of equipment donated by the Department of Health and Social Security (DHSC) for the NHS's response to the Covid-19 Pandemic. The total capital value of equipment received by the Trust totalled 2021/22: £47k. No further receipt of Covid related equipment has been received by the Trust during 2022/23.

### Note 18 Revaluations of property, plant and equipment and intangibles (Group)

As described in note 6 to the Accounts 'Impairment of Assets', the Trust commissioned the District Valuation Office to undertake a full desk top revaluation during the course of 2022/23, namely: -

Provision of a **v**aluation for land and buildings that were surplus to Trust needs and were available for sale; provision of a valuation of land and building assets not currently available for sale and a valuation of land, and provision for buildings and dwellings in use as at 31st March 2023. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but available for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value.

The overall net impact of the above revaluations has been to increase the value of the Trust's Property, Plant and Equipment items by £2,645k (2021/22 £3,630k). Of this net increase, a net expense of £8,419k has been charged against operating expenditure as an 'Impairment' (2021/22: net credit of £1,139k) and the balance of £11,064k (2021/22 £2,491k) has been credited to the revaluation reserve.

Torbay and South Devon NHS Foundation Trust

## Note 19 Right of use assets - Group and Trust

### Note 19.1 Right of use assets - 2022/23

| Group | Property (land and buildings) * £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Intangible assets £000 | Total £000 | Of which leased from DHSC group bodies £000 |
|---|---|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2022 - brought forward** | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets | 561 | 6,317 | 685 | 5,885 | 40 | **13,488** | 0 |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | 9,444 | 905 | 200 | 0 | 0 | **10,549** | 580 |
| Additions | 4,358 | 331 | 35 | 0 | 0 | **4,724** | 428 |
| Reversal of impairments | 32 | 0 | 0 | 0 | 0 | **32** | 0 |
| Revaluations | (83) | 0 | 0 | 0 | 0 | **(83)** | 0 |
| Reclassifications | 0 | 208 | 0 | (208) | 0 | **0** | 0 |
| **Valuation/gross cost at 31 March 2023** | **14,312** | **7,761** | **920** | **5,677** | **40** | **28,710** | **1,008** |
| | | | | | | | |
| **Accumulated depreciation at 1 April 2022 - brought forward** | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| IFRS 16 implementation - reclassification to right of use assets | 0 | 1,692 | 415 | 1,332 | 4 | **3,443** | 0 |
| Provided during the year - right of use asset | 1,099 | 1,215 | 182 | 1,023 | 6 | **3,525** | 77 |
| Provided during the year - peppercorn leased asset | 70 | 0 | 0 | 0 | 0 | **70** | 70 |
| Revaluations | (93) | 0 | 0 | 0 | 0 | **(93)** | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| **Accumulated depreciation at 31 March 2023** | **1,076** | **2,907** | **597** | **2,355** | **10** | **6,945** | **147** |
| | | | | | | | |
| **Net book value at 31 March 2023** | **13,236** | **4,854** | **323** | **3,322** | **30** | **21,765** | **861** |

* - Property (land and buildings) additions, value of £4,358k includes a sum of £3,600k for an asset which remained an asset under the course of construction as at 31st March 2023 but in line with IFRS16 the asset was capitalised from the recognition of the lease liability. The liability cystalising during 2022/23.

# Torbay and South Devon NHS Foundation Trust

## Note 20 Investments in Subsidiary, Associates and joint ventures

The Trust's principal subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out in these financial statements.

The reporting data of the financial statements for the subsidiary is the same as for these group financial statements - 31 March 2023.

### Investment in Subsidiary - SDH Developments Ltd

The Trust's wholly owned subsidiary company is registered in the UK, company no. 08385611 with a share capital comprising one share £1 owned by the Trust. The company commenced trading on 1st July 2013 as an Outpatients Dispensing service in Torbay Hospital and a significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The Group position for 2022/23 incorporates a subsidiary post-tax profit of £117k (2021/22 £113k). The subsidiary's gross and net assets at 31st March 2022 were £2,179k (2021/22 £2,289) and £893k (2021/22 £776k) respectively. The management of the subsidiary company produce their own tax computations, supported with professional advice which due to ethical standards the auditors can no longer produce. There has been no significant change in the trading risks during the course of this year.

### Investments in associates and joint ventures outside of the government accounting boundary

| | Group and Trust | |
|---|---|---|
| | 2022/23 | 2021/22 |
| | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **0** | **65** |
| Transfer to assets held for sale | 0 | (65) |
| **Carrying value at 31 March** | **0** | **0** |

During 2016/17 the Trust invested £35,000 in a Limited Liability Partnership trading as 'Health and Care Innovations LLP'. A further £30,000 investment was made by the Trust during 2019/20. The Trust held a 50% equity stake in the business. The principal purpose of the LLP was to develop, produce and market healthcare related educational videos. During 2021/22, the Trust agreed to sell its stake in the business, with this sale due to be completed in 2022/23, and the investment was therefore been recognised as an asset held for sale. The completion of the sale has now taken place during 2022/23. On the grounds of materiality the Trust had not consolidated the results of the LLP into the 2021/22 financial results.

During 2018/19 the Trust together with a Partner formed a LLP named 'SDH Innovations Partnership LLP'. The Trust holds a 50% equity stake in the business, namely share capital of £1 nominal value. The principal purpose of the LLP is a vehicle to support the development of new healthcare facilities with a Strategic Estates Partner. On the grounds of materiality the Trust has not consolidated the results of the LLP into these financial statements.

## Note 21 Inventories

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2023 | 31 March 2022 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| Drugs | 2,640 | 2,534 | 1,953 | 1,844 |
| Consumables | 3,082 | 2,957 | 3,082 | 2,957 |
| Energy | 65 | 24 | 65 | 24 |
| Other * | 7,672 | 5,880 | 7,672 | 5,880 |
| **Total inventories** | **13,459** | **11,395** | **12,772** | **10,705** |
| **of which:** | | | | |
| Held at fair value less costs to sell | 0 | 0 | 0 | 0 |

* Other Inventories includes £7,212k of stock manufactured by the Trust's Pharmacy Manufacturing Unit in readiness for sale as well as associated raw materials (2021/22 £5,547k).

Inventories recognised in expenses for the year were £56,226k (2021/22: £52,742k). Of the inventories recognised in expense £582k related to Consumables donated from DHSC group bodies (2021/22 £1,315k). Write-down of inventories recognised as expenses for the year totalled £93k (2021/22: £121k). Of the Write down of inventories recognised as expenses for the year none related to Consumables from DHSC group bodies (2021/22 £0k).

# Torbay and South Devon NHS Foundation Trust

## Note 22 Receivables

### Note 22.1 Receivables total

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | Note | 31 March 2023 £000 | 31 March 2022 £000 | 31 March 2023 £000 | 31 March 2022 £000 |
| **Current** | | | | | |
| Contract receivables (IFRS15) : invoiced * | | 16,608 | 14,503 | 16,608 | 14,503 |
| Contract receivables (IFRS 15) : not yet invoiced / non-invoiced ** | | 18,546 | 7,391 | 18,625 | 7,421 |
| Allowance for impaired contract receivables / assets | | (2,503) | (1,674) | (2,503) | (1,674) |
| Prepayments (non-PFI) | | 3,885 | 4,162 | 3,885 | 4,162 |
| PDC dividend receivable | | 267 | 1,021 | 267 | 1,021 |
| VAT receivable | | 1,182 | 1,840 | 992 | 1,662 |
| Other receivables | | 1,156 | 154 | 1,156 | 154 |
| **Total current trade and other receivables** | | **39,141** | **27,397** | **39,030** | **27,249** |
| **Non-current** | | | | | |
| Contract receivables (IFRS 15) : not yet invoiced / non-invoiced * & ** | | 588 | 437 | 588 | 437 |
| Finance lease receivables | 28.2 | 501 | 501 | 501 | 501 |
| Clinician pension tax provision reimbursement funding from NHS England *** | | 451 | 500 | 451 | 500 |
| Other receivables | | 0 | 0 | 338 | 375 |
| **Total non-current trade and other receivables** | | **1,540** | **1,438** | **1,878** | **1,813** |
| **Of which receivables from NHS and DHSC group bodies:** | | | | | |
| Current | | 19,756 | 9,543 | 19,756 | 9,543 |
| Non-current | | 693 | 743 | 693 | 743 |

*** Contract receivables (IFRS15) : invoiced,** includes Adult Social Care Debt of £7,274k (2021/22 £6,297k).

**** Contract receivables (IFRS15) : not yet invoiced / non invoiced.** includes NHS Injury Unit receivables £1,238k (2021/22 £1,087k)

**& **** The value of Contract receivables at 31st March 2023 in comparison with the position at 31st March 2022 has increased substantially due to the inclusion of the Substantive non consolidated pay offer to NHS employees in respect of the financial year 2022/23. This offer is still being discussed by National staffside and National NHS Management and therefore had not been cash transacted as at 31st March 2023. A corresponding liability is contained in note 25, Trade and Other Payables to these accounts.

***** Clinician pension tax provision reimbursement funding from NHS England,** relates to monies due to offset the potential liability the Trust is exposed to in underwriting the tax liabilities Clinicians are facing relating to increases in their Pensions above and above their Annual Allowances in respect of 2020/21. Please refer to 'Provisions' - note 29 to these financial statements for further analysis.

# Torbay and South Devon NHS Foundation Trust

## Note 22 Trade receivables and other receivables

### Note 22.2 Allowance for credit losses - 2022/23

| | Group and Trust | | |
|---|---|---|---|
| | Contract receivables and contract assets £000 | All other receivables £000 | Total £000 |
| **Allowance at 1 April 2022** | **1,674** | **0** | 1,674 |
| New allowances arising | 1,261 | 0 | 1,261 |
| Reversals of allowances | (48) | 0 | (48) |
| Utilisation of allowances (write offs) | (384) | 0 | (384) |
| **Allowance at 31 March 2023** | **2,503** | **0** | **2,503** |
| **Loss recognised in expenditure** | **1,213** | **0** | **1,213** |

### Note 22.3 Allowance for credit losses - 2021/22

| | Group and Trust | | |
|---|---|---|---|
| | Contract receivables and contract assets £000 | All other receivables £000 | Total £000 |
| **Allowances as at 1 April 2021** | **1,019** | **0** | 1,019 |
| New allowances arising | 790 | 0 | 790 |
| Reversals of allowances | (13) | 0 | (13) |
| Amounts utilised | (122) | 0 | (122) |
| **Allowance at 31 March 2022** | **1,674** | **0** | **1,674** |
| **Loss recognised in expenditure** | **777** | **0** | **777** |

## Torbay and South Devon NHS Foundation Trust

### Note 22.4 Credit quality of financial assets (continued)

The Trust undertakes a regular review of its aged debt analysis to ensure that invoices are settled in a prompt manner and to ensure that any debts that show signs of being disputed are escalated appropriately. If as a consequence of an investigation the likelihood of debt recovery is remote, an allowance for credit loss is made. As described in Note 3.2 Operating Income, a general allowance for expected credit losses is applied to NHS Recovery Unit debts as advised by DHSC. The Trust also applies a general provision for expected credit losses against its Adult Social Care client contribution debtors. This general provision is based upon a forward looking view supplemented with long standing historical experience of recovering these type of debts. The general provision has been reviewed due to the impact that both COVID-19 and increased cost of living challenges has had on Adult Social Care debt levels.

The Trust has reviewed the value of its non impaired debts associated with non Adult Social Care Client contributions beyond their settlement dates and has concluded that these debts are likely to be recoverable.

### Note 23 Non-current assets held for sale and assets in disposal groups

| | Group and Trust | |
|---|---|---|
| | 2022/23 | 2021/22 |
| | £000 | £000 |
| **NBV of non-current assets for sale and assets in disposal groups at 1 April** | **2,452** | **687** |
| Assets classified as available for sale in the year | 0 | 1,765 |
| Assets sold in year | (65) | 0 |
| Impairment of assets held for sale | (285) | 0 |
| **NBV of non-current assets for sale and assets in disposal groups at 31 March** | **2,102** | **2,452** |

During the course of 2022/23, none of the three assets being marketed for sale as at 31st March 2022 have been disposed of. Two are vacant properties and the other is a surplus piece of land. The Trust anticipates that the disposals will take place during the next twelve months.

### Note 24 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | Group | | Trust | |
|---|---|---|---|---|
| | 2022/23 | 2021/22 | 2022/23 | 2021/22 |
| | £000 | £000 | £000 | £000 |
| **At 1 April** | **39,342** | **45,445** | **39,008** | **45,212** |
| Net change in year | (4,608) | (6,103) | (4,363) | (6,204) |
| **At 31 March** | **34,734** | **39,342** | **34,645** | **39,008** |
| **Broken down into:** | | | | |
| Cash at commercial banks and in hand | 120 | 356 | 31 | 22 |
| Cash with the Government Banking Service | 34,614 | 38,986 | 34,614 | 38,986 |
| **Total cash and cash equivalents as in SoFP and SoCF** | **34,734** | **39,342** | **34,645** | **39,008** |

## Torbay and South Devon NHS Foundation Trust

### Note 25 Trade and other payables

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2023 £000 | 31 March 2022 £000 | 31 March 2023 £000 | 31 March 2022 £000 |
| **Current** | | | | |
| Trade payables | 9,074 | 8,956 | 9,074 | 8,956 |
| Capital payables | 13,104 | 13,641 | 13,104 | 13,641 |
| Accruals * | 48,234 | 32,738 | 48,254 | 32,734 |
| Social security costs | 6,203 | 5,981 | 6,203 | 5,981 |
| Other taxes payable | 38 | 46 | 0 | 0 |
| PDC dividend payable | 0 | 0 | 0 | 0 |
| Pension contributions payable | 4,167 | 3,908 | 4,167 | 3,908 |
| Other payables * | 1,340 | 1,809 | 1,593 | 1,708 |
| **Total current trade and other payables** | **82,160** | **67,079** | **82,395** | **66,928** |
| **Of which payables to NHS and DHSC group bodies:** | | | | |
| Current | 8,759 | 4,546 | 8,759 | 4,546 |

* The value of Accruals at 31st March 2023 in comparison with the position at 31st March 2022 has increased substantially due to the inclusion of the Substantive non consolidated pay offer to NHS employees in respect of the financial year 2022/23. This offer was still being discussed by National staffside and National NHS Management and therefore had not been cash transacted as at 31st March 2023. A corresponding contract receivable is contained in note 22, Receivables to these accounts.

### Note 25.1 Early retirements in NHS payables above

| | Group and Trust | | | |
|---|---|---|---|---|
| | 31 March 2023 £000 | 31 March 2022 £000 | 31 March 2023 Number | 31 March 2022 Number |
| - to buy out the liability for early retirements over 5 years | 0 | 0 | | |
| - number of cases involved | | | - | - |

### Note 26 Other liabilities

| | Group and Trust | |
|---|---|---|
| | 31 March 2023 £000 | 31 March 2022 £000 |
| **Current** | | |
| Deferred income : contract liabilities | 8,015 | 10,293 |
| **Total other current liabilities** | **8,015** | **10,293** |

### Note 27 Borrowings

| | | Group and Trust | |
|---|---|---|---|
| | Note | 31 March 2023 £000 | 31 March 2022 £000 |
| **Current** | | | |
| Loans from DHSC | 27.3 | 3,065 | 4,034 |
| Obligations under finance leases | 28.6 | 3,503 | 2,130 |
| Obligations under PFI or other service concession contracts (excl. lifecycle) | 34.1 | 1,276 | 1,312 |
| **Total current borrowings** | | **7,844** | **7,476** |
| **Non-current** | | | |
| Loans from DHSC | 27.3 | 22,291 | 25,209 |
| Obligations under finance leases | 28.6 | 18,280 | 7,841 |
| Obligations under PFI or other service concession contracts | 34.1 | 14,012 | 15,288 |
| **Total non-current borrowings** | | **54,583** | **48,338** |

**Torbay and South Devon NHS Foundation Trust**

**Note 27 Borrowings - continued**

**Note 27.1 Borrowings - Reconciliation of liabilities arising from financing activities 2022/23 (Group & Trust)**

| | Note | Total from financing activities £000 | DHSC loans £000 | Finance Leases £000 | PFI obligations £000 |
|---|---|---|---|---|---|
| Carrying value at 1 April 2022 | | 55,814 | 29,243 | 9,971 | 16,600 |
| Implementation of IFRS16 on 1st April 2022 | 28.4 | 10,374 | 0 | 10,374 | 0 |
| **Cash movements:** | | | | | |
| Financing cash flows - (payments) and receipt of principal * | | (8,471) | (3,867) | (3,292) | (1,312) |
| Financing cash flows - (payments) of interest - excludes contingent rent | | (2,103) | (706) | (398) | (999) |
| **Non-cash movements:** | | | | | |
| Additions | | 4,724 | 0 | 4,724 | 0 |
| Application of effective interest rate | | 2,089 | 686 | 404 | 999 |
| **Carrying value at 31 March 2023** | | **62,427** | **25,356** | **21,783** | **15,288** |

* - Additions for DHSC cash flows are netted off within 'Financing cash flows principal'

**Note 27.2 Borrowings - Reconciliation of liabilities arising from financing activities 2021/22 (Group & Trust)**

| | Total from financing activities £000 | DHSC loans £000 | Finance Leases £000 | PFI obligations £000 |
|---|---|---|---|---|
| Carrying value at 31 March 2022 | 63,658 | 34,067 | 11,825 | 17,766 |
| **Cash movements:** | | | | |
| Financing cash flows - (payments) and receipt of principal * | (7,935) | (4,805) | (1,964) | (1,166) |
| Financing cash flows - (payments) of interest - excludes contingent rent | (2,339) | (833) | (415) | (1,091) |
| **Non-cash movements:** | | | | |
| Additions | 126 | 0 | 126 | 0 |
| Application of effective interest rate | 2,304 | 814 | 399 | 1,091 |
| **Carrying value at 31 March 2022** | **55,814** | **29,243** | **9,971** | **16,600** |

* - Additions for DHSC cash flows are netted off within 'Financing cash flows principal'

**Torbay and South Devon NHS Foundation Trust**

**Note 27 Borrowings - continued**

**Note 27.3 Loans from DHSC**

**The interest rates and terms of the Loans from DHSC are as follows: -**

**Group and Trust**

| | Total principal and interest outstanding at 31 March 2023 | Interest Rate | Interest outstanding at 31st March 2023 and repayable within one year | Loan principal due within one year | Total current liability as at 31st March 2023 | Loan principal repayments due after more than one year at 31 March 2023 | Duration of Loan | Date of final loan repayment | Total outstanding at 31 March 2022 |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | % | £000 | £000 | £000 | £000 | Years | £000 | £000 |
| **Loans for Capital Developments** | | | | | | | | | |
| Backlog Maintenance 2011/12 | 4,373 | 3.41% | 43 | 540 | 583 | 3,790 | 20 | Dec 2030 | 4,918 |
| Backlog Maintenance 2012/13 | 4,759 | 1.90% | 3 | 527 | 530 | 4,229 | 20 | Mar 2032 | 5,287 |
| Pharmacy Manufacturing Freehold | 4,320 | 2.99% | 4 | 411 | 415 | 3,905 | 20 | Sep 2033 | 4,732 |
| Pharmacy Manufacturing Fit-out | 0 | 3.14% | 0 | 0 | 0 | 0 | 12 | Sep 2022 | 951 |
| Critical Care Unit and Hospital Front Entrance | 8,535 | 2.34% | 72 | 706 | 778 | 7,757 | 20 | Nov 2034 | 9,247 |
| Linear Accelerator Bunker and associated enabling works | 2,273 | 2.34% | 19 | 188 | 207 | 2,066 | 20 | Nov 2034 | 2,463 |
| Replacement Linear Accelerator | 666 | 1.66% | 4 | 331 | 335 | 331 | 10 | Feb 2024 | 999 |
| Car Parking Facilities | 430 | 1.66% | 3 | 214 | 217 | 213 | 10 | Nov 2024 | 646 |
| Sub-total; Capital loans | **25,356** | | **148** | **2,917** | **3,065** | **22,291** | | | **29,243** |

| | 31 March 2023 Total | 31 March 2023 Interest | 31 March 2023 Principal | 31 March 2022 Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| of which payable within: - | | | | |
| - not later than one year; | **3,065** | **148** | **2,917** | **4,034** |
| - later than one year and not later than five years; | **10,032** | **0** | **10,032** | **10,578** |
| - later than five years. | **12,259** | **0** | **12,407** | **14,631** |

**Torbay and South Devon NHS Foundation Trust**

## Note 28 Finance leases

### Note 28.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

| | Group and Trust |
|---|---|
| | 2022/23 |
| | £000 |
| Finance lease receivables at 31 March 2022 | 501 |
| Interest arising (unwinding of discount) | 59 |
| Lease receipts (cash payments received) | (59) |
| Finance lease receivables at 31 March 2023 | **501** |

### Note 28.2 Finance lease receivables maturity analysis as at 31 March 2023

| | Group and Trust | |
|---|---|---|
| | Total | Of which leased to DHSC group bodies: |
| | 31 March 2023 | 31 March 2023 |
| | £000 | £000 |
| **Undiscounted future lease receipts receivable in:** | | |
| not later than one year; | 59 | 19 |
| later than one year and not later than two years; | 59 | 19 |
| later than two years and not later than three years; | 59 | 19 |
| later than three years and not later than four years; | 60 | 20 |
| later than four years and not later than five years; | 60 | 20 |
| later than five years. | 2,361 | 948 |
| **Total future finance lease payments to be received** | **2,658** | **1,045** |
| Estimated value of unguaranteed residual interest | 0 | 0 |
| Unearned interest income | (2,157) | (803) |
| Allowance for uncollectable lease payments | 0 | 0 |
| **Net investment in lease (net lease receivable)** | **501** | **242** |
| **of which:** | | |
| Leased to other NHS providers | 242 | |

The finance lease receivables relates to the lease of three properties to the South West Ambulance Service NHS Foundation Trust, two of which expire in 2090 and one in 2071, and the lease of part of the Torbay Hospital Annexe site to South Devon College which expires in 2063.

### Note 28.3 Finance lease receivables maturity analysis as at 31 March 2022 (IAS 17 basis)

| | Group and Trust |
|---|---|
| | 31 March 2022 |
| | £000 |
| **Gross lease receivables** | **2,717** |
| of which those receivable: | |
| - not later than one year; | 59 |
| - later than one year and not later than five years; | 238 |
| - later than five years. | 2,420 |
| Unearned interest income | (2,216) |
| **Net lease receivables** | **501** |
| of which those receivable: | |
| - not later than one year; | 0 |
| - later than one year and not later than five years; | 3 |
| - later than five years. | 498 |
| | |
| The unguaranteed residual value accruing to the lessor | 0 |
| Contingent rents recognised as income in the period | 0 |

**Torbay and South Devon NHS Foundation**

### Note 28.4 Finance Lease as a Lessee - Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note .

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

**Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022**

| | Group and Trust |
|---|---|
| | 1 April 2022 |
| | £000 |
| **Operating lease commitments under IAS 17 at 31 March 2022** | **10,523** |
| Impact of discounting at the incremental borrowing rate | |
| **IAS 17 operating lease commitment discounted at incremental borrowing rate** | **(670)** |
| **Less:** | |
| Commitments for short term leases | (461) |
| Commitments for leases of low value assets | |
| Commitments for leases that had not commenced as at 31 March 2022 | |
| Irrecoverable VAT previously included in IAS 17 commitment | (660) |
| Services included in IAS 17 commitment not included in the IFRS 16 liability | |
| **Other adjustments:** | |
| Public sector leases without full documentation previously excluded from operating lease commitments | 504 |
| Finance lease liabilities under IAS 17 as at 31 March 2022 | 9,971 |
| Other adjustments | 1,138 |
| **Total lease liabilities under IFRS 16 as at 1 April 2022** | **20,345** |

**Torbay and South Devon NHS Foundation**

### Note 28.5 Finance Lease as a lessee

| | Group and Trust |
|---|---|
| | 2022/23 |
| | £000 |
| Carrying value at 31 March 2022 | 9,971 |
| IFRS 16 implementation - adjustments for existing operating leases as at 1st April 2022 | 10,374 |
| **Sub-total** | **20,345** |
| Lease additions | 4,724 |
| Interest charge arising in year | 404 |
| Lease payments - principal (cash outflows) | (3,292) |
| Lease payments - interest (cash outflows) | (398) |
| Carrying value at 31 March 2023 | **21,783** |

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure. These payments are disclosed in Note 5. Operating Expenses within these financial statements. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above."

### Note 28.6 Finance Lease as a lessee

Obligations under finance leases where the trust is the lessee.

| | Group and Trust | |
|---|---|---|
| | Total | Of which leased from DHSC group |
| | 31 March 2023 | 31 March 2023 |
| | £000 | £000 |
| **Gross lease liabilities** | **25,717** | **724** |
| of which liabilities are due: | | |
| - not later than one year; | 3,998 | 109 |
| - later than one year and not later than five years; | 11,358 | 438 |
| - later than five years. | 10,361 | 177 |
| Sub-total | 25,717 | 724 |
| Finance charges allocated to future periods | (3,934) | (45) |
| **Net lease liabilities** | **21,783** | **679** |

### Note 28.7 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

| | Group and Trust |
|---|---|
| | 31 March 2022 |
| | £000 |
| **Undiscounted future lease payments payable in:** | |
| - not later than one year; | 2,419 |
| - later than one year and not later than five years; | 7,431 |
| - later than five years. | 878 |
| **Total gross future lease payments** | **10,728** |
| Finance charges allocated to future periods | (757) |
| **Net finance lease liabilities at 31 March 2022** | **9,971** |
| of which payable: | |
| - not later than one year; | 2,130 |
| - later than one year and not later than five years; | 6,974 |
| - later than five years. | 867 |

## Torbay and South Devon NHS Foundation Trust

### Note 29 Provisions

| | Group and Trust | | | | | |
|---|---|---|---|---|---|---|
| **Group and Trust** | **Pensions : early departure costs** | **Pensions : Injury benefits** | **Legal claims** | **Lease dilapidations amounts previously charged to revenue** | **Clinician Pension Tax reimbursement** | **Total** |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| **At 1 April 2022** | **851** | **4,409** | **227** | **435** | **500** | **6,422** |
| Change in the discount rate | (79) | (1,020) | 0 | 0 | (397) | **(1,496)** |
| Arising during the year | 59 | 31 | 108 | 0 | 342 | **540** |
| Utilised during the year | (105) | (223) | (119) | 0 | (3) | **(450)** |
| Reversed unused | (20) | 0 | (11) | 0 | 0 | **(31)** |
| Unwinding of discount | 14 | 75 | 0 | 0 | 9 | **98** |
| **At 31 March 2023** | **720** | **3,272** | **205** | **435** | **451** | **5,083** |
| **Expected timing of cash flows:** | | | | | | |
| - not later than one year; | 78 | 167 | 205 | 0 | 0 | **450** |
| - later than one year and not later than five years; | 312 | 668 | 0 | 0 | 0 | **980** |
| - later than five years. | **330** | **2,437** | **0** | **435** | **451** | **3,653** |
| - Sub-total; more than one year | **642** | **3,105** | **0** | **435** | **451** | **4,633** |
| **Total** | **720** | **3,272** | **205** | **435** | **451** | **5,083** |

The provision entitled 'pensions early departure costs' has two components. The provision for early retirement and injury benefit payments to staff have been based on information from NHS Pensions. The principal uncertainty relating to this is the life expectancy of the beneficiaries.

The provision entitled 'legal claims' relates to personal injury claims received from employees and members of the public. These claims have been quantified according to the guidance received from the NHSLA and the relevant insurance companies. Due to the inherent uncertainty of this type of claim it has been assumed that any of the claims dealt with by the insurance companies will be settled and paid during the year ending 31 March 2023. The potential liability has been split into two parts with one part being provided for and the second part included in Contingencies at Note 31.

The provision entitled 'Clinician Pension Tax reimbursement' relates to a potential liability that the Trust will face to underwrite the tax liability faced by clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. The Trust will make a contractually binding commitment to pay clinicians in this position a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect in retirement. Due to the timescale for pension tax annual allowance (AA) charges and the scheme pays nominations, there is no data of the ‘actual’ nominations for the 2019-20 tax year available; the deadline for initial nomination is 31 July 2021, with the ability to make changes up to 31 July 2024. The Trust has recognised a provision liability in line with the estimate provided to the Trust by NHS England. The Trust's liability to these costs have been underwritten by NHS England and therefore a corresponding Receivable has been included in note 22 to these financial statements

### Note 30 Clinical negligence liabilities

At 31 March 2023, £110,118k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Torbay and South Devon NHS Foundation Trust (31 March 2022: £159,161k).

## Torbay and South Devon NHS Foundation Trust

### Note 31 Contingent assets and (liabilities)

| | Group and Trust | |
|---|---|---|
| | 31 March 2023 | 31 March 2022 |
| | £000 | £000 |
| **Value of contingent (liabilities)** | | |
| NHS Resolution legal claims | (61) | (87) |
| Employment tribunal and other related litigation | 0 | (4) |
| Other | (1,416) | (1,485) |
| **Gross value of contingent (liabilities)** | **(1,477)** | **(1,576)** |
| Amounts recoverable against liabilities | 0 | 0 |
| **Net value of contingent (liabilities)** | **(1,477)** | **(1,576)** |
| **Net value of contingent assets** | **0** | **0** |

**Personal Injury Claims**

The Trust receives a number of personal injury claims from employees and members of the public. The NHS Resolution administer the scheme and provide details of the liability and likely value of claims. The value of the claims which have been assessed as being unlikely to succeed for which no provision has been made in the accounts is £61,000 (2021/22 £87,000).

**Employment tribunal and other related litigation**

At 31 March 2023, there were three such cases ongoing (31st March 23 - two cases). It has not been possible to quantify the potential liability or assess the likelihood of a liability arising, a contingent liability of £0 (2021/22: £10,000) is disclosed.

**Centre for Health & Care Professions - South Devon College**

The Trust entered into a lessor finance lease South Devon College on 1st September 2017 to enable the College to use part of the Trust's Torbay Hospital Annexe site as an educational facility. The Secretary of State for Education loaned the College a sum of money to invest in the site. This external investment does not form part of the Trust's Statement of Financial Position, but the value of the Trust buildings now leased to the College have been classified in the Trust's accounts as a finance lease. The lease is for a 50 year period, with a break point at year 30. If during the course of the primary lease period (i.e. the first 30 years) South Devon College (or successor organisation) was to cease the delivery of education (for whatever reason), then the Trust would be obliged to pay a sum to the Secretary of State for the capital invested by he Department of Education. The potential sum payable diminishes over time but at 31st March 2023 the potential liability would be £1.4m (31st March 2022 £1.5m). No provision for this potential liability has been made, as the likelihood of this liability crystallising is considered remote.

### Note 32 Contractual capital commitments

| | Group & Trust | |
|---|---|---|
| | 31 March 2023 | 31 March 2022 |
| | £000 | £000 |
| Property, plant and equipment | 6,834 | 11,453 |
| Intangible assets | 59 | 316 |
| **Total** | **6,893** | **11,769** |

### Note 33 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2023 | 31 March 2021 | 31 March 2023 | 31 March 2021 |
| | £000 | £000 | £000 | £000 |
| not later than 1 year | 20,366 | 18,019 | 20,323 | 10,462 |
| after 1 year and not later than 5 years | 0 | 0 | 0 | 0 |
| paid thereafter | 0 | 0 | 0 | 0 |
| **Total** | **20,366** | **18,019** | **20,323** | **10,462** |

Torbay and South Devon NHS Foundation Trust

## Note 34 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has two PFI contracts for two Community Hospital facilities, namely Dawlish Community Hospital and Newton Abbot Community Hospital. Both contracts meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, and are therefore accounted for as 'on-Statement of Financial Position'

### Dawlish Hospital

Dawlish Hospital has a value of £146k at 31st March 2023 (31st March 2022 £302k)

The Trust entered into an agreement under the Private Finance Initiative (PFI) arrangements for the construction of a new community hospital in Dawlish. The contract for the arrangement runs from 22nd June 1999 with a term of 25 years.

On 1 April 2002 this arrangement passed to Teignbridge Primary Care Trust (a predecessor body of Northern, Eastern and Western Devon CCG). On 1 April 2013 it passed to Torbay and Southern Devon Health and Care NHS Trust. On 1 October 2015 it returned to the Trust through the transfer of absorption of Torbay and Southern Devon Health and Care NHS Trust.

From the commencement of the contract a service fee of £241,000 was payable each year subject to indexation based upon RPI.

For the twelve month period 2022-23 that the Trust operated the scheme the unitary payment was £1,292k (2021-22 £1,206k).

**Arrangement** - The contract is for the provision of services for maintenance, domestics and catering staff for the hospital. The ownership of the equipment and content rests with the Trust. The arrangement works on the principal of 'no hospital, no fee'. The provision of services is managed through service level agreements, which have measurable targets and are subject to regular monitoring.

**Terms of Arrangemen**t - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPIX) All items, excluding mortgage interest payments'. Services are subject to market testing approximately every 5 years, and increases and decreases in costs from these regular market testing exercises are passed through to the Trust. At the end of the project term the Trust may allow the lease to expire with no compensation payable, or the parties may agree commercial terms for an extension of the agreement for a further 10 years, or have an option to acquire the leasehold interest and collapse the entire Lease structure by paying open market value for the land and buildings. In the event of re-financing of the PFI the Trust is entitled to receive half of the refinancing cash flow benefits. The Trust has now served notice on the PFI Operator that it intends to purchase the freehold from the Operator at the end of the current PFI term, i.e. June 2024.

### Newton Abbot Hospital

On 11th April 2007 Devon Primary Care Trust (now reconfigured and named NHS Devon CCG) entered into an agreement under the Private Finance Initiative (PFI) arrangement for the construction of a new community hospital at Jetty Marsh, Newton Abbot. The capital value of the scheme was £21,980,000

The construction of the hospital was completed on 18th December 2008. From that date the unitary payment was £2,103,669 each year subject to annual RPI indexation movement for a period of 30 years. For the twelve month period in 2022-23 the unitary payment was £3,205k (2021-22 £2,952k). Newton Abbot Hospital has a value of £20,167k at 31st March 2022 (31st March 2022 £17,296k).

**Arrangement** - The contract is for the provision of maintenance services for this hospital. The ownership of the equipment between the parties is specified in the Agreement. The arrangement works on the basis of a reduction in the payments for failure to deliver to the agreed service levels. The provision of services is managed through service level agreements which have measurable targets and are subject to regular monitoring.

**Terms of Arrangemen**t - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

**Torbay and South Devon NHS Foundation Trust**

## Note 34 On-SoFP PFI, LIFT or other service concession arrangements, continued

### Note 34.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

| | Group and Trust | | | |
|---|---|---|---|---|
| | 31 March 2023 | | | 31 March 2022 |
| | Dawlish | Newton Abbot | Total | Total |
| | £000 | £000 | £000 | £000 |
| **Gross PFI, LIFT or other service concession liabilities** | **752** | **22,715** | **23,467** | **25,778** |
| **Of which liabilities are due** | | | | |
| - not later than one year; | 645 | 1,525 | 2,170 | 2,311 |
| - later than one year and not later than five years; | 107 | 5,129 | 5,236 | 6,083 |
| - later than five years. | 0 | 16,061 | 16,061 | 17,384 |
| Finance charges allocated to future periods | (84) | (8,095) | (8,179) | (9,178) |
| **Net PFI, LIFT or other service concession arrangement obligation** | **668** | **14,620** | **15,288** | **16,600** |
| - not later than one year; | 571 | 705 | 1,276 | 1,312 |
| - later than one year and not later than five years; | 97 | 2,159 | 2,256 | 2,903 |
| - later than five years. | 0 | 11,756 | 11,756 | 12,385 |

### Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

| | Group and Trust | | | |
|---|---|---|---|---|
| | 31 March 2023 | | | 31 March 2022 |
| | Dawlish | Newton Abbot | Total | Total |
| | £000 | £000 | £000 | £000 |
| Total future payments committed in respect of the PFI service concession arrangements | 1,483 | 65,503 | 66,986 | 65,737 |
| **Of which liabilities are due:** | | | | |
| - not later than one year; | 1,237 | 3,635 | 4,872 | 4,481 |
| - later than one year and not later than five years; | 246 | 15,073 | 15,319 | 14,948 |
| - later than five years. | 0 | 46,795 | 46,795 | 46,308 |

The values of the above total future obligations include estimated allowances for the impact of future inflation that will be applied to the variable elements of the two PFI contracts. An assumption has been made that RPI of 13.84% will be applied to the Newton Abbot PFI in 2023/24. It has been assumed that RPIX of 7.26% will be applied to the Dawlish PFI contract in 2023/24. In 2024/25 and beyond the following inflationary assumptions have been applied to bot PFI contracts, i.e. Inflation of 0.6% per annum for 2024/25 and 2.0% per annum will apply thereafter, these two rates being provided by HM Treasury.

### Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

| | Group and Trust | | | |
|---|---|---|---|---|
| | 31 March 2023 | | | 31 March 2022 |
| | Dawlish | Newton Abbot | Total | Total |
| | £000 | £000 | £000 | £000 |
| **Unitary payment payable to service concession operator** | | | | |
| **Consisting of:** | | | | |
| - Interest charge | 140 | 859 | 999 | 1,091 |
| - Repayment of finance lease liability | 603 | 709 | 1,312 | 1,166 |
| - Service element and other charges to operating expenditure | 447 | 551 | 998 | 937 |
| - Revenue lifecycle maintenance | 102 | 212 | 314 | 302 |
| - Contingent rent | 0 | 848 | 848 | 662 |
| **Total Unitary payment** | **1,292** | **3,179** | **4,471** | **4,158** |
| **Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment** | 0 | 26 | 26 | 15 |
| **Total amount paid to service concession operator** | **1,292** | **3,205** | **4,497** | **4,173** |

**Torbay and South Devon NHS Foundation Trust**

### Note 35 Financial instruments

#### Note 35.1 Financial risk management

A financial instrument is a contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another enterprise.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The financial assets and liabilities of the Trust are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

#### Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other receivables. Surplus operating cash is only invested with UK based Clearing banks. The Trust's cash assets are held with National Westminster Bank plc., the Office of the Government Banking Service and Citibank only. An analysis of receivables and provision for impairment can be found at note 22, trade and other receivables.

Because of the continuing service provider relationship that the Trust has with local clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of credit risk faced by many other business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

#### Liquidity risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

The Trust's net operating costs are incurred largely under annual service agreements with local clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has secured eight Independent Trust Financing Facility (ITFF) Loans, details of which are disclosed in note 27 to the accounts. These loans were used to enable the Trust to invest in replacement infrastructure of Torbay Hospital, namely investment in backlog maintenance; enabled the expansion of the Trusts Pharmacy Manufacturing Unit (PMU); construction of a new Critical Care Unit and Hospital Front Entrance; improvement of Car Parking Facilities and continuation of the Trust's Radiotherapy service. Interest on these loans are fixed. The loan principal repayment and interest rates on these loans are disclosed in note 27.3.

During 2015/16 the Trust acquired two Private Finance Initiative (PFI) contracts, in respect of Newton Abbot and Dawlish community hospitals. Further details of the contracts are given in Note 34. The unitary payments for the Newton Abbot contract are subject to annual indexation in accordance with RPI (excluding mortgage interest payments). However, the associated risk is not judged to be significant, as these payments are equivalent to less than 1% of Trust turnover. With regard to the Dawlish contract, the availability fee is fixed and the service fee is subject to periodic market testing (meaning that the cost should be no greater than if the contract did not exist and the services were purchased externally).

#### Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balance, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash flows are substantially independent of changes in market interest rates. Therefore, the Trust is not exposed to significant interest-rate risk.

## Torbay and South Devon NHS Foundation Trust

### Note 35.2 Carrying values of financial assets

| | Group 31 March 2023 | | Group 31 March 2022 | |
|---|---|---|---|---|
| | Held at amortised cost | Total book value | Held at amortised cost | Total book value |
| | £000 | £000 | £000 | £000 |
| **Carrying value of financial assets as at 31 March under IFRS 9** | | | | |
| Trade and other receivables (excluding non financial assets) | 35,347 | 35,347 | 21,812 | 21,812 |
| Other investments / financial assets | 2,102 | 2,102 | 2,452 | 2,452 |
| Cash and cash equivalents | 34,734 | 34,734 | 39,342 | 39,342 |
| **Total** | **72,183** | **72,183** | **63,606** | **63,606** |

| | Trust 31 March 2023 | | Trust 31 March 2022 | |
|---|---|---|---|---|
| | Held at amortised cost | Total book value | Held at amortised cost | Total book value |
| | £000 | £000 | £000 | £000 |
| **Carrying value of financial assets as at 31 March under IFRS 9** | | | | |
| Trade and other receivables (excluding non financial assets) | 35,426 | 35,426 | 21,842 | 21,842 |
| Other investments / financial assets | 2,440 | 2,440 | 2,827 | 2,827 |
| Cash and cash equivalents | 34,645 | 34,645 | 39,008 | 39,008 |
| **Total** | **72,511** | **72,511** | **63,677** | **63,677** |

**Torbay and South Devon NHS Foundation Trust**

## Note 35.3 Carrying values of financial liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | Held at amortised cost | | Held at amortised cost | |
| | 31 March 2023 | 31 March 2022 | 31 March 2023 | 31 March 2022 |
| **Other financial liabilities** | £000 | £000 | £000 | £000 |
| **Liabilities as per SoFP** | | | | |
| Loans from the Department of Health and Social Care | 25,356 | 29,243 | 25,356 | 29,243 |
| Obligations under finance leases | 21,783 | 9,971 | 21,783 | 9,971 |
| Obligations under PFI, LIFT and other service concession contracts | 15,288 | 16,600 | 15,288 | 16,600 |
| Trade and other payables excluding non financial liabilities | 72,683 | 57,778 | 72,956 | 57,883 |
| **Total** | **135,110** | **113,592** | **135,383** | **113,697** |

## Note 35.4 Maturity of financial liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2023 | 31 March 2022 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| In one year or less | 82,535 | 67,248 | 82,808 | 67,143 |
| In more than two years but not more than five years | 28,430 | 26,157 | 28,430 | 26,157 |
| In more than five years | 39,617 | 34,186 | 39,617 | 34,186 |
| **Total** | **150,582** | **127,591** | **150,855** | **127,486** |

## Note 35.5 Fair Values

The book value of assets and liabilities (excluding loans from the Department of Health and Social Care) due after 12 months is estimated to be the same as the fair value of the assets and liabilities.

The fair value of Loans from the Department of Health and Social Care should be classed as being held at Current Value. They are however currently reflected at Amortised Cost. The valuations of these loans are again estimated to be the fair value of these loans.

## Torbay and South Devon NHS Foundation Trust

### Note 36 Losses and special payments

| Group and trust | 2022/23 Total number of cases Number | 2022/23 Total value of cases £000 | 2021/22 Total number of cases Number | 2021/22 Total value of cases £000 |
|---|---|---|---|---|
| **Losses** | | | | |
| Cash losses | 9 | 23 | 10 | 3 |
| Bad debts and claims abandoned | 181 | 420 | 195 | 302 |
| Stores losses and damage to property | 2 | 0 | 6 | 1 |
| **Total losses** | **192** | **443** | **211** | **306** |
| **Special payments** | | | | |
| Ex-gratia payments | 30 | 28 | 21 | 12 |
| **Total special payments** | **30** | **28** | **21** | **12** |
| **Total losses and special payments** | **222** | **471** | **232** | **318** |
| Compensation payments received | | 0 | | 0 |

### Note 37 Related parties

Torbay and South Devon NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. The Foundation Trust forms part of the Government's 'Whole Government Accounting' framework along with other NHS and Local Authority bodies. The Trust's parent is the Department of Health and Social Care and the ultimate parent is HM Government

### Note 37.1 Related parties - Key Management (Group and Trust)

**Key Management personnel** - Key management includes directors, both executive and non-executive. The compensation paid or payable in aggregate to Key management for employment services is shown in the Annual Report and summarised in Note 5 to the Accounts 'Operating Expenditure'. None of the Key management personnel received an advance from the Trust. The Trust has not entered into any guarantees of any kind on behalf of Key management personnel. There were no amounts owing to Key management personnel at the beginning or end of the financial year.

During 2022/23 and 2021/22 the Trust transacted with related parties on whose Boards the Trust's non-executive directors and directors had similar chair or non-executive roles, or other interests. The value of transactions entered into were as follows: -

| | Income 2022/23 £000 | Income 2021/22 £000 | Receivables 31 March 2023 £000 | Receivables 31 March 2022 £000 |
|---|---|---|---|---|
| Age UK Torbay | 0 | 0 | 0 | 0 |
| Devon Care Homes Collaborative Ltd | 23 | 0 | 0 | 0 |
| | **23** | **0** | **0** | **0** |

| | Expenditure 2022/23 £000 | Expenditure 2021/22 £000 | Payables 31 March 2023 £000 | Payables 31 March 2022 £000 |
|---|---|---|---|---|
| Age UK Torbay | 101 | 144 | 0 | 0 |
| Devon Care Homes Collaborative Ltd | 0 | 18 | 0 | 18 |
| JSL Consulting & Associates Ltd | 0 | 1 | 0 | 0 |
| Ogwell Grange Ltd | 23 | 0 | 6 | 0 |
| | **124** | **163** | **6** | **18** |

## Torbay and South Devon NHS Foundation Trust

### Note 37 Related parties (continued)

### Note 37.2 Non-consolidated Associates & Joint Ventures (Group and Trust)

| | Income | | Receivables | |
|---|---|---|---|---|
| | 2022/23 | 2021/22 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| Health and Care Innovations LLP | - | 0 | - | 0 |
| SDH Innovations Partnership LLP | 0 | 0 | 0 | 0 |
| | **0** | **0** | **0** | **0** |

| | Expenditure | | Payables | |
|---|---|---|---|---|
| | 2022/23 | 2021/22 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| Health and Care Innovations LLP | - | 214 | - | 18 |
| SDH Innovations Partnership LLP | 2,663 | 2,025 | 108 | 0 |
| | **2,663** | **2,239** | **108** | **18** |

The Trust sold its' equity stake in Health and Care Innovations LLP during the course of 2021/22 and the asset was classed as an Asset held for sale as at 31st March 2022. The sale completion took place during 2022/23.

The transactions with SDH Innovations Partnership LLP mostly relate to the construction of Land excluding Dwellings projects. SDH Innovations Partnership LLP's registration is OC424178. Its registered office is, 9th Floor Cobalt Square, 83-85 Hagley Road, Birmingham, United Kingdom, B16 8QG.

### Note 37.3 Related Parties - Charity (Group and Trust)

The Trust also receives charitable contributions from a number of generous charitable and other bodies. These are channelled through Torbay and South Devon NHS Charitable Fund, for which the Foundation Trust is Corporate Trustee. The registered number of the charity is 1052232, the registered office is Regent House, Regent Close, Torquay TQ2 7AN. During the year, the Trust received revenue contributions of £1,419,000 (2021/22: £934,000) and capital of £1,694,000 (2021/22: £252,000) from the charity. The charity had reserves of £1,505,000 as at 31st March 2023 and recorded a decrease in funds of £255,000 during the year ended 31st March 2022. The balance of receivables due from the charity at 31st March 2023 was £220,000 (31st March 2022 £49,000).

### Note 37.4 Consolidated Subsidiary (Trust)

| | Income | | Receivables | |
|---|---|---|---|---|
| | 2022/23 | 2021/22 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| SDH Developments Ltd | 600 | 406 | 48 | 412 |
| | **600** | **406** | **48** | **412** |

| | Expenditure | | Payables | |
|---|---|---|---|---|
| | 2022/23 | 2021/22 | 31 March 2023 | 31 March 2022 |
| | £000 | £000 | £000 | £000 |
| SDH Developments Ltd | 11,542 | 11,406 | 1,099 | 951 |
| | **11,542** | **11,406** | **1,099** | **951** |

SDH Developments Ltd is a company registered in the UK. Its registration number is 08385611 and its registered address is Regent House, Regent Close, Torquay, TQ2 7AN.

## Note 37 Related parties (continued)

### Note 37.5 Related Parties -Whole Government Accounting (Group and Trust)

During the year Torbay and South Devon NHS Foundation Trust has had a number of material transactions with the Department of Health and Social Care (DHSC) and other entities for which DHSC is regarded as parent of those entities. Income from these DHSC entities are reported in either note 3 - Operating Income or note 4 - Other Operating Income to these financial statements. Expenditure with these entities forms part of the Trust's Operating Expenditure - note 5 to these financial statements.

The DHSC Related Party transactions that are the most material in value to Torbay and South Devon NHS Foundation Trust and the nature of the primary relationship are described below

| | | |
|---|---|---|
| Devon Partnership NHS Trust | | Principle sub-contractor to the provision of the Children's & Family Health Devon contract |
| Health Education England | | Provide income to the Trust to facilitate the delivery of training to healthcare staff |
| NHS Devon ICB | | The Trust's main commissioner of patient care services. |
| NHS England | | Main commissioner of specialised and high cost services provided by the Trust |
| NHS Resolution | | Provision of litigation cover |
| Northern Devon Healthcare NHS Trust | ) | Provision of clinical, internal audit and other services to one another |
| Royal Devon United Hospitals Foundation Trust | ) | |
| University Hospitals Plymouth NHS Trust | ) | |
| NHS Pension Scheme | | Provision of post employment benefits to Staff and Directors of the Trust |

<table>
<tr><td colspan="4">Report to the Board of Directors</td></tr>
<tr><td colspan="3">Report title: Quality Account 2022/23</td><td>Meeting date:<br>28th June 2023</td></tr>
<tr><td>Report appendix</td><td colspan="3">Quality Account 2022/23</td></tr>
<tr><td>Report sponsor</td><td colspan="3">Chief Nurse</td></tr>
<tr><td>Report author</td><td colspan="3">Chief Nurse</td></tr>
<tr><td>Report provenance</td><td colspan="3"></td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">Please find enclosed a final draft of the 2022/23 Quality Account.<br><br>The Board’s attention is drawn to the key areas of progress made in 2022/23 against the quality Improvement priorities.<br><br>The Board will note Priorities for 2022/23 are for both acute and community services and greater emphasis will be given to drawing out community data position around Fundamentals of Care, Patient Experience and Deteriorating patients.<br><br>The Priorities for 2023/24 are as follows:<br><br>1. Safety: Delivery of SOF 4 Exit criteria - Reduction in Harm resulting from of delays in access to treatment across planned and emergency care<br>2. Effectiveness: Continued focus on 2022/23 priorities to ensure sustained and long term improvements<br>3. Experience: Enhanced Experience for patients when leaving hospital and focused improvements in Care of the Elderly<br><br>Please note the partner statements will be added to the Quality Account once received.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information<br>☐</td><td>To receive and note<br>☐</td><td>To approve<br>☒</td></tr>
<tr><td>Recommendations</td><td colspan="3">The Board of Directors is asked to approve Quality Account for the year ended 31 March 2023; and</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
</table>

Public

<table>
<tr><td rowspan="2">Strategic objectives supported by this report</td><td>Safe, quality care and best experience</td><td></td><td>Valuing our workforce</td><td></td></tr>
<tr><td>Improved wellbeing through partnership</td><td></td><td>Well-led</td><td>X</td></tr>
<tr><td rowspan="2">Is this on the Trust’s Board Assurance Framework and/or Risk Register</td><td>Board Assurance Framework</td><td>n/a</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>n/a</td><td>Risk score</td><td></td></tr>
<tr><td rowspan="3">External standards affected by this report and associated risks</td><td>Care Quality Commission</td><td>X</td><td>Terms of Authorisation</td><td>X</td></tr>
<tr><td>NHS Improvement</td><td>X</td><td>Legislation</td><td>X</td></tr>
<tr><td>NHS England</td><td>X</td><td>National policy/guidance</td><td>X</td></tr>
</table>

Our People

# Quality Account 2022/23

BUILDING A Brighter Future

improving health & care in Torbay & South Devon

1

# Quality Account 2022/23

Approved by Trust Board on 28 June 2023
Includes commissioner feedback received on XXX

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# ABOUT THIS DOCUMENT

The content of this account and its publication on our website is a regulatory requirement for NHS organisations. However, we want our quality account to be a meaningful and easy-to-use reference point for people wanting to get a sense of the quality of our services.

To this end we have aimed to make this account as clear and user-friendly as possible so that everyone can understand the quality of the services provided last year and see what we will be doing to improve our services in the year ahead.

For NHS services the definition of quality is broadly accepted as having the following dimensions:

- patient safety
- clinical effectiveness
- experience of care.

It is through these categories that we define our quality priorities and measure how we are doing in delivering them.

Further information about quality accounts in general can be found at: https://www.nhs.uk/using-the-nhs/about-the-nhs/quality-accounts/about-quality-accounts/

For more information about our services, or to tell us what you think about this report or anything we do please contact us at communications.tsdft@nhs.net.

# 1 INTRODUCTION AND STATEMENT OF QUALITY

### About us

We are a proud integrated health and care organisation of more than eight years' standing. We serve our local people by providing community care, including adult social care and acute care, from Torbay Hospital as well as four community hospitals stretching from Dawlish to Brixham.

Increasingly, we are providing more care as close to home as possible for our people; reducing their need to travel and helping to keep them safe and live well. More and more we are delivering care directly into people's homes either through visits, online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

Making sure people are safe is at the heart of what we do. This not only includes the people we care for in our hospitals and in our communities but also our dedicated staff.

We have made significant advances over the years in leading and innovating care across a range of clinical services.

As a well-established integrated care organisation, we know the value of working in partnership with others and the positive impact this has for our local population. In progressing our quality agenda, we are committed to including and listening to our people and communities to improve our understanding of their needs and acting together to deliver better health and care for all.

During the past year we have taken further steps to strengthen our partnerships across the Devon health and care system. Together we have developed a single improvement plan that places quality and patient safety at the heart of how we work, making it the principal driver for change in how we collectively deliver against our identified strategic quality improvements.

Our three-year quality and safety plan outlines our approach to quality, setting out our ambition for excellence and outstanding care through a set of strategic quality goals and improvement priorities. Drawing on the NHS Patient Safety Strategy 2019 and international best practice, this document sets out our ambitions and the actions we will take to make our vision a reality.

In this year's Quality Account, we reflect on the strategic changes that are taking place to address the systemic issues and challenges that impact the quality and safety of care as well as share the improvements being made against the clinical improvement priorities agreed against our four quality goals.

### Our vision of excellence in quality

We are committed to delivering outstanding care, ensuring excellence in experience and outcomes for our people who use our services and the wider communities we serve.

While there is no universal definition of 'excellent care', it is important to be clear about what we are aiming to achieve– providing clarity on our purpose enables us to know when we are not delivering against our ambition for both people who use our services and those who work within our services (our dedicated staff).

Our vision of excellent care means that we aim to:

- ✓ meet the needs of the people we serve, ensuring care is compassionate and person centred and that it is focused on what matters to patients, families and carers
- ✓ provide care that is free from harm and where the clinical outcomes are comparable with the best in the world
- ✓ empower and enable our people to deliver the very best care
- ✓ establish the infrastructure and foster the culture that empowers and enables our talented people to focus on the things that matter most to them
- ✓ work in partnership to improve the quality of care and reduce health inequalities with patients our staff and partners across the Devon health and social care system.

## Our quality goals

Our understanding of quality reflects the description of quality as set out in the '*High Quality for All, NHS Next Stage Review' (2008).* The three components of quality; safety, effectiveness and patient experience are linked. A service cannot be judged to be excellent because it is safe while ignoring its effectiveness or people's experience.

We held a number of listening and engagement sessions with our people between February and June 2021 to help us identify our key issues and explore the options to address them. Together we co-designed our four quality and safety goals which are aligned to our vision for better health and care for all.

In this year's Quality Account, we will share our progress against the clinical improvement priorities we agreed against the four quality goals, specifically:

- ✓ sepsis
- ✓ deteriorating patient
- ✓ falls
- ✓ nutrition and hydration
- ✓ experience of patients on discharge.

## *Summary of our quality report*

I am pleased to introduce our quality account for 2022/23.

There is no doubt the quality and safety of care has been tested in the last three years. While the COVID-19 pandemic has been declared officially over by the World Health Organisation, people living and working in our local communities continue to be significantly affected by the consequences of the pandemic.

Waiting lists for many services are much longer than any of us would wish and people are experiencing unacceptable delays in treatment and accessing services which is having an adverse impact on their experience and clinical outcomes.

The scale of the challenges we are facing serves to highlight the importance of service transformation and finding new ways to support and treat people who need our care, particularly ways in which wellbeing can be maintained and ill health prevented for both physical and mental health. Our vision is, and remains, better health and care for all.

Never has our commitment to quality and patient safety been more important. We are committed to reinforcing and enhancing our culture of safety, enabling our people to feel safe and confident to speak up. We are embedding a quality improvement approach at every level and this year we have launched our new quality boards which we are rolling out across all services.

Our new compassionate leadership framework will ensure we listen and act upon what people tell us. Being civil and respecting each other are central to creating a just learning culture that will help us deliver all aspects of our work and will help us to make patient safety everyone's business.

The ongoing challenges we are facing and the understandable stresses these are causing again only serve to highlight the importance of focusing on the health and wellbeing of our people so that we can deliver the best care we can.

We have made it a priority to reduce our reliance on agency staff and increase our activity around recruitment as well as developing homegrown talent through our successful apprenticeship programmes.
A further key element to our approach to quality includes a continued focus on building meaningful partnerships, with our patients, community, our staff and colleagues across the health and care system ensuring that we are listening to what matters to our people and reflecting this in our work.

We are committed to putting people at the centre of our thinking and working more closely with colleagues from different organisations. There are examples of how we are doing this throughout our quality account.

As we look to the future it is vital that we strengthen these relationships and develop collaboration across not only clinical but also corporate and operational services.

I commend this quality account to you and confirm that, to the best of my knowledge, the information in the document is accurate.

Liz Davenport
Chief Executive Officer, Torbay and South Devon NHS Foundation Trust

# 2.1 PRIORITIES FOR IMPROVEMENT

## IMPROVEMENT PRIORITIES FOR 2022/23 – HOW WE DID

Throughout the year we remained relentlessly focused on addressing the quality and safety challenges that emerged across our services following the pandemic.

We have taken a number of significant steps to ensure that wherever a patient is cared for, acute and/or community services, we collectively work together to deliver the very best care, and achieving the best outcomes and experience and we are very proud of the improvements that have been made across health and social care. Working together we have progressed significant improvement in quality of services and this account brings together some examples of this across our acute, community and adult social care services.

Along with our partner NHS organisations across Devon, we entered into a higher level of regulatory support and monitoring in 2022. This has required us to work together differently to address the more systemic quality and patient safety issues that have emerged in care and treatment across the NHS and in particular the community we serve in Torbay.

We strengthened our partnership across health and social care to ensure we are better placed to address risks of delay in access to treatment.

In 2022/23, we developed a single quality improvement plan across Devon to address issues of quality and safety of care, with specific targets around improvements to reduce/eliminate long waits for planned and emergency care. We are pleased that we have made progress in these areas.

Alongside this Quality Account for Health, we will also be publishing in September our annual account of Quality and Performance for Adult Social Care and the following serves to highlight some of the important quality improvements across key services.

### Emergency care

We continued to see significant challenges around delays in our communities accessing and being seen across the emergency pathway and we have implemented a range of improvements that started to have a positive impact over the winter and spring of 2022/23. These included the completion of our long awaited £15.7 Acute Medical Unit (AMU) opened its doors in December 2022.

Our AMU is a flag ship for our building a brighter future programme which aims to make a real difference to how we deliver services to and for our people. In addition, new pathways have been embedded over the last year alongside the development of virtual wards, which provides significant additional activity of 28 beds, which will be further developed in 2023/24 to deliver 77 urgent care beds, providing specialist clinical observation and management in people’s own homes.

### Cancer care

The delivery of high-quality cancer care has been a key focus of our improvement work and we recognise that there is more we must do. During 2022/23 we were placed into Tier 1 scrutiny for cancer performance. We put a significant focus on improving cancer services and by March 2023 we had:

- ✓ met the standard for Faster Diagnostics with performance at 77% in March 2023

- ✓ sustained a significant reduction in the number of patients waiting more than 62 days for urgent suspected cancer, meeting the target for reduction
- ✓ delivered all of the Tier 1 performance improvement thresholds resulting in a recommendation that we exit Tier 1 monitoring.

### Planned care

We have worked hard to reduce long waiting times for planned outpatients and operations supported by a significant programme of quality improvements. We know that long waits for planned procedures or appointments has a significant impact on people's health and wellbeing and we are committed to continuing to drive this improvement further in 2023/24.

The number of people who are waiting longest for our services is steadily and sustainably reducing including the following achievements by March 2023:

- ✓ no one waiting longer than 104 weeks
- ✓ significant reduction in people waiting for longer than 78 weeks (183 people at year end).

Our focus is the continued reduction in the number of people waiting more than 65 weeks and we are receiving external support to drive improvement aligned with the outpatient and surgical care transformation programme to maintain improvement into 2023/24.

### Community Services

Our Community services progressed a range of quality initiatives in 2022/23 some of which included the following:

- ✓ *Lower Limb Therapy Service:* The Trust was recommissioned in 2021 to care for all patients who require compression bandaging across the organisations footprint. The impact has been significant to the population with the healing rate having reduced from 24wks to 5wks to time to heal, this is obviously having a significant impact on individuals and their wellbeing.
- ✓ *Homeless Wound Care Clinic:* A clinic has been set up in Factory Row in Torquay for homeless people to self-present regarding wound care and ongoing wound care needs. This has increased the quality of patients' lives. It has also allowed patients journeys to me more seamless as the Tissue Viability Team will see these individuals on admission and support wards in the management of wound care, and they already have established relationships with clients who feel engaged in their treatment.
- ✓ *Trusted Assessors:* The introduction of two Trusted Assessors has improved patients experience and quality relating to discharge to Care Homes. The Trusted Assessors have built up relationships with the Care Homes which has resulted in Care Homes feeling confident in the assessments provided. It has developed further in that Care Homes at times are using the Trusted Assessors to provide an assessment to prevent any delays in assessment and acceptance. As a result confidence in discharges to Care Homes has improved, patient experience will be better and length of stay has been reduced where they may have previously been delays with Care Homes being able to come in and assess individuals. Given the success this has been funded to continue to 2024.
- ✓ Occupational Therapy In Reach Service*:* this initiative has allowed patients to be reviewed prior to discharge to ensure they are on the correct pathway and will be in receipt of right support on discharge. The impact has been reduced length of stay, reduced deconditioning and better patient outcomes.

- ✓ *0-19 Service:* The 0-19 service has been part of a pilot along with 13 other areas nationally who have introduced Family Hubs. Funding has been sourced nationally through local authority to establish multiagency family hubs. These hubs are designed and are improving outcomes to families through a multiagency response/involvement within a deprived areas.
- ✓ *Drugs and Alcohol Team:* Coproduced multicomplex service working in partnership with Devon Partnership Trust and Jatis to provide services to individuals who are exposed to substance and alcohol misuse and homelessness. This has seen an improvement in service user engagement. There has also been a reduction in deaths since implantation and although it is unclear if this is direct outcome it is felt that there is correlation. It has improved access to a broader range of services which improves better health and wellbeing for the service users.

## Adult Social Care

In 2022/23 were further enhanced the integrated to developing and delivering services with Adult Social Care. While the Annual Adult Social Care Account will set our progress and improvements in Adult Social Care across Torbay in 20922/23. Building on the success of the integration and partnership with Torbay Local Authority, since July 2022 we have worked as one health and care system through a strategic approach entitled 'One Devon'. This strategy is focused on enabling partners across health and care to share our valuable resources and knowledge to provide joined-up care for the people who need us with five key areas of focus for improvement that include:

1. mental health
2. healthy ageing
3. good start to life
4. complex needs
5. Digital inclusion.

The following highlights draw attention to not only the increasing demand and level of complex care required within our community, it demonstrated the responsiveness of ASC Services.

- ➢ 8,420 requests for support were received compared to 5,407 in 2020/21
- ➢ 771 people received one-off support compared to 443 in 2020/21
- ➢ 2,226 people received Short Term Reablement services to help them gain independence compared to 1,275 in 2020/21
- ➢ 1,092 people started to receive an ongoing support service including community activities compared to 544 in 2020/21
- ➢ 100% of service users received community based social care services through self-directed support
- ➢ 4,747 carers are on Torbay's carers register - we assessed and reviewed 1,355 carers in 2020/21 and provided 678 carers with Direct Payments
- ➢ 386 people with mental health issues were supported by compared to 343 in 2020/21
- ➢ 1,775 people received home care support to enable them to stay in their own home compared to 1,729 in 2020/21
- ➢ 949 people were in permanent residential placements during 2021/22 compared to 930 in 2020/21
- ➢ 998 safeguarding concerns were raised. This represents a 9.1% decrease in the 1,098 safeguarding concerns raised in 2010/21

## Delivery against our quality and patient safety strategy

During the year we:

- ✓ developed a just culture framework that sets out clearly the intentions that must be in place to ensure we are fostering and promoting a culture of psychological safety for our people
- ✓ launched our just culture survey - the results will enable us to better understand the barriers we face in building culture of psychological safety and how we can work together to address these
- ✓ ensured the voice of people who use our services shaped how we recognise and reward our people through the continued roll out the Daisy and newly launched Primrose award
- ✓ rolled out a revised ward accreditation framework with stretch targets around specific quality improvements
- ✓ rolled out our quality boards – a visual tool within quality improvement methodology that aid services to chart and map quality improvement, providing both focus and a way to recognise achievement.

## Clinical quality improvement priorities

Throughout the year we demonstrated improvements in key areas but we recognise that more must be done in 2023/24 to ensure improvements are sustained.

Our improvement goals for 2022/23 were to achieve:

- ✓ 100% compliance with sepsis bundle
- ✓ 100% compliance with all risk assessments for people who are admitted to hospital
- ✓ 100% compliance with nutrition and hydration risks within 24 hours of admission to hospital
- ✓ reducing the number falls resulting in harm when in hospital
- ✓ 100% compliance in vital signs undertaken within the prescribed timescale
- ✓ 100% compliance with early warning score recorded
- ✓ Improved patient experience around discharge.

## Quality priority one: improve identification and management of sepsis

Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. All NHS organisations focus on ensuring that when a person presents with symptoms that may be related to sepsis, key clinical interventions are initiated in line with the national standards are described as the 'sepsis bundle'.

Our aim in 2022/23 was to improve our identification and management of people with sepsis to reduce the number of people who die from septic shock.

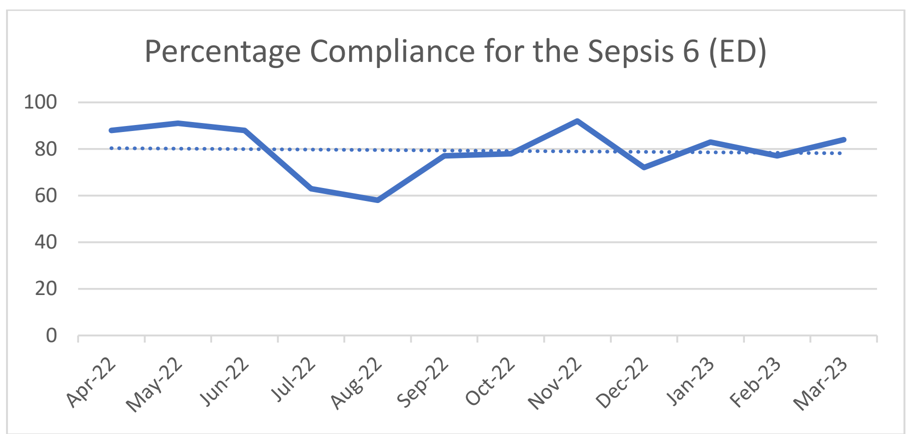
Our primary focus has been within our Emergency Department with roll out plan across high risk areas in 2023.

**Key interventions delivered include:**

- ✓ we strengthened the clinical leadership for the quality improvement program
- ✓ we established the overarching Sepsis Improvement Group and established the audit framework.
- ✓ we introduced a new audit tool
- ✓ we commissioned new training package for clinical teams.

### How did we do?

Against a goal of 100% compliance with the sepsis bundle, we achieved 80% on average in our Emergency Department (ED).




## Quality priority two: improve compliance around patient risk assessments

For us this means getting the fundamentals of care right every time. On admission to hospital and when being looked after in the community there are a range of risk assessments that must be undertaken to ensure we are identifying people at risk including falls, and malnutrition and dehydration.

In doing so we can safely and appropriately put in place care interventions that are personal and most relevant to a person's need. Our aims in 2022/23 were to:

- ✓ achieve 100% compliance with all risk assessments for people who are admitted to hospital
- ✓ reduce the number of frail people falling when in hospital
- ✓ ensure everyone is assessed for nutrition and hydration risks within 24 hours of admission to hospital.

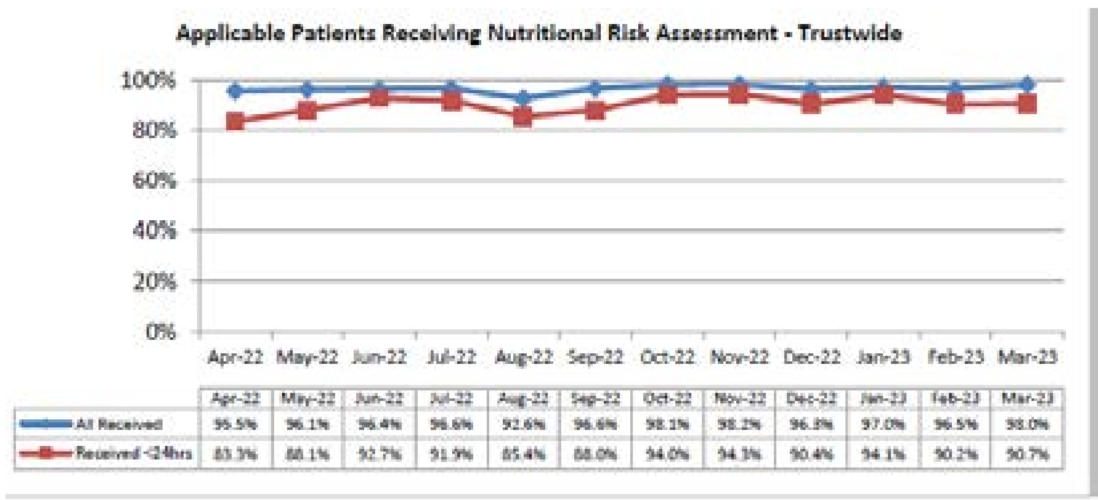
## Risk assessments and nutrition and hydration

### Key interventions delivered include:

- ✓ five a day audit of patient notes
- ✓ daily review by nurse in charge
- ✓ establishing our nutrition and hydration council to focus on improvement interventions
- ✓ launching our nutrition and hydration campaign in spring of 2022
- ✓ relaunching protected mealtimes on our wards
- ✓ introducing greater daily monitoring in the 'five a day' audit
- ✓ increasing meal time companions (from eight to 42)
- ✓ introduced more robust governance process.

## How did we do?

We achieved a 98% compliance for nutrition and hydration risk assessments being in March and an average of 96.4% compliance over 2022/23 however there is more we must do to ensure these are undertaken within the four-hour time scale of admission as this level of compliance is lower and while there has been a more sustained improvement in the lastr months of 2022/23 , this still falls below the 100%




| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All Received | 95.5% | 96.1% | 96.4% | 96.6% | 92.6% | 96.6% | 98.1% | 98.2% | 96.3% | 97.0% | 96.5% | 98.0% |
| Received <24hrs | 83.3% | 88.1% | 92.7% | 91.9% | 85.4% | 88.0% | 94.0% | 94.3% | 90.4% | 94.1% | 90.2% | 90.7% |

## Falls reduction

We recognised that there was a need to reduce the number of falls our people with frailty were sustaining when in our hospital care. Research has shown that multifactorial assessments and interventions that identify and treat the underlying reasons for falls can reduce falls by around 25%.

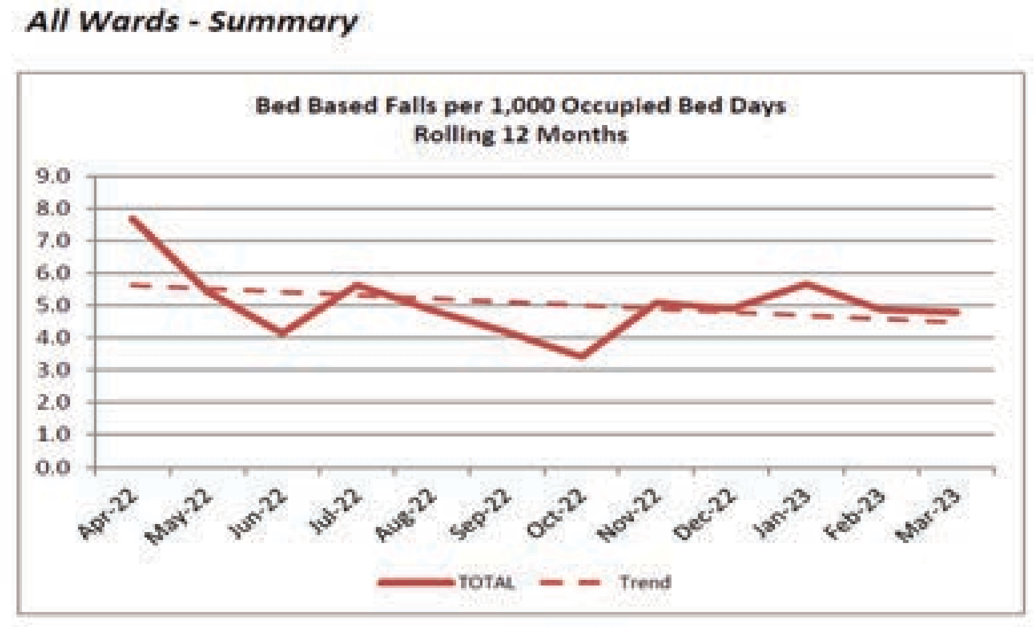
During the year we strengthened the application of the fall safe bundle which sets out a number of critical care interventions that can reduce the risk of people falling, some of which include making sure people have the correct footwear, visual assessments, appropriate lighting and call bells being near to hand. This year we introduced the requirement for people identified as being at risk of falling to have their lying and standing blood pressure recoded.

**Key interventions delivered include:**

- ✓ fall safe bundle imbedded including a 'lying and standing blood pressure'
- ✓ training 'lying and standing blood pressure'
- ✓ we are now achieving 45% compliance against a national average of 39% for lying and standing blood pressure being recorded
- ✓ visual assessment tool has been piloted and will roll out and add to fall safe bundle
- ✓ fall debrief being piloted.

## How did we do?

In terms of a reduction in falls, the number of bed-based falls is reducing – we are currently seeing 4.8 falls per 1,000 against 6.1 in the previous year which identifies a 27% reduction in falls.



## *Quality priority three: improved identification of deteriorating patient*

We said we would focus on improving clinical outcomes by better supporting people whose condition is deteriorating when they are in hospital. This means ensuring all appropriate physiological observations are recorded at their initial assessment to inform a clear plan for further observations throughout their stay.

**Key interventions delivered included:**

- ✓ strengthened and rolled training in NEWs 2, target uplift to 100%
- ✓ regular monitoring through the deteriorating patient group
- ✓ targeted support for wards where there is underperformance

### How did we do?

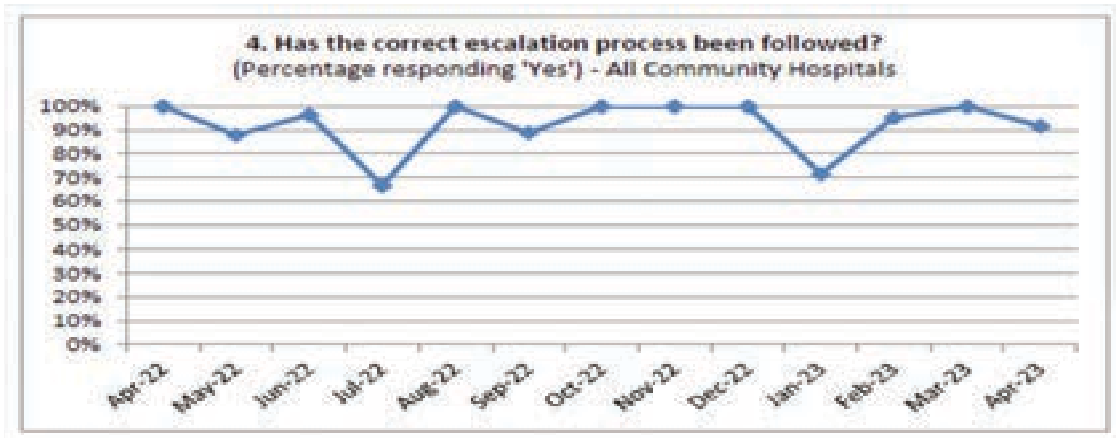
Our compliance with recording vital signs within the specified timescale

- ✓ performance of 98% vs target of 100%.

Completion of the early warning score (a physiological "track and trigger" system)

- ✓ performance of 100% meets our target.

Audit of escalation shows 100% across surgery in March, however this needs to be consistent and measured across all our inpatient services.



## Quality priority four: improved experience for people being discharged

Preparing patients and their families around discharge home is a key priority. Ensuring that patients are involved in decisions about their care and the appropriate arrangements are made to ensure that the transition home is safe, personal and compassionate is crucial to their wellbeing.

### Key interventions included:

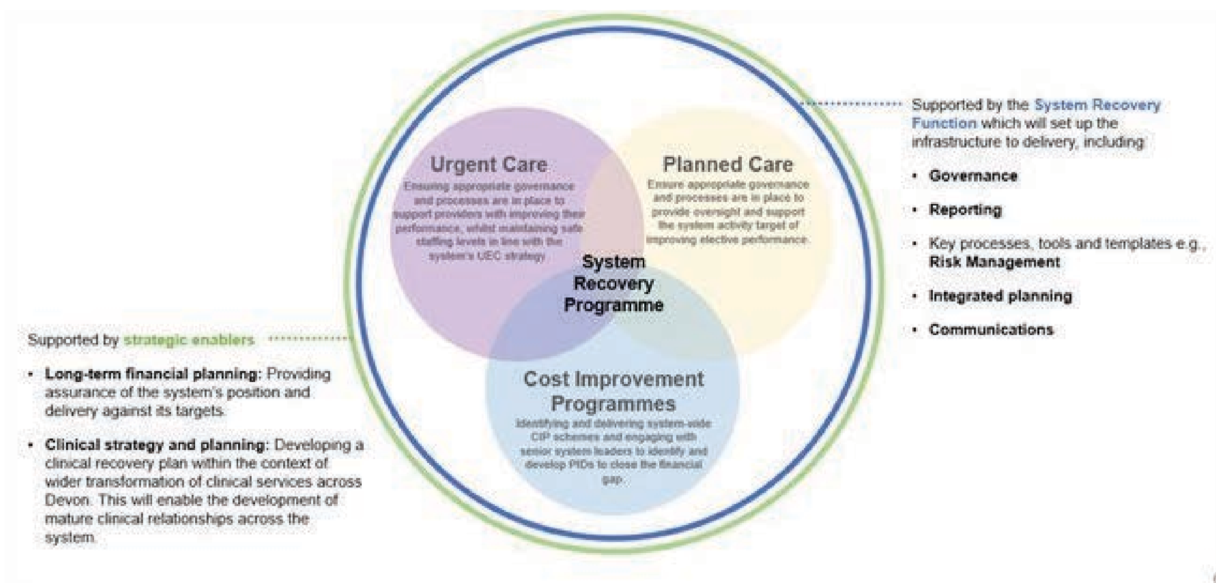
- ✓ introduced home for lunch Initiative
- ✓ enhanced discharge lounge
- ✓ targeted support for wards where there is underperformance
- ✓ review of preferred place of discharge
- ✓ follow-up of patients around person centred care

### How did we do?

- ✓ patient feedback through the NHS patient survey 2023 showed we were performing in the top 20% in the following:
  - involved in decisions about your discharge
  - after leaving hospital did you get enough support
  - were you given enough information
- ✓ home for lunch: in March 2023 19.3% of people were discharged before 12 noon compared to 67.3% before 5pm
- ✓ enhanced discharge lounge – promoting a positive step to discharge - the number of people transitioning through our discharge lounge has doubled
- ✓ deep dive review underway looking at preferred place of discharge, current data shows 74% patients were discharged to their preferred place of care
- ✓ patient survey – ten randomly selected people who have been discharged each month to be called to collect themes on their experience of discharge due to start in the first quarter of 2023/4.

## IMPROVEMENT PRIORITIES FOR 2023/24 – THE YEAR AHEAD

In 2023/24 our focus will be to deliver sustained improvements across acute and community services with a specific focus on planned and emergency care and delivery against the improvement targets set out by the national and regional team. In doing so we will work with system partners to ensure that we deliver against our commitments to address issues of inequity and inequalities emerging post pandemic. These will include the following improvement priorities:




### Quality priority one: reduce harm resulting from delays in access to planned and emergency care

Our first priority is to deliver improvements across planned and unplanned services that will reduce harm associated with delays in care. Our ambitions are aligned with those of the wider Devon health and care system, which locally we are calling our regain and renew plan.

This is a new quality priority for 2023/24 to reflect the critical and urgent need to ensure there is consistent quality and equitable access to safe services across Devon. We will be working closely with Devon partners for many aspects of these plans, but the key goals that we have committed to deliver within our own organisation by March 2024 are as follows.

Key measures for unplanned care

- ✓ reduce ambulance handover delays greater than 15 minutes to 1,110
- ✓ increase the number of patients seen in ED within four hours to 76%
- ✓ reduce to zero the number of patients waiting more than 12 hours to be seen in ED
- ✓ increase pre-midday discharges to 35%
- ✓ reduce the number of people unnecessarily staying in hospital to 5%.

Key measures for planned care
- ✓ eliminate all waits over 78 weeks
- ✓ reduce waits over 65 weeks to 1,091
- ✓ diagnose 75% of GP-referred patients within 28 days
- ✓ reduce the number of cancer patients waiting over 62 days to 138.

In concert with the above, we will deliver the following improvement measures in collaboration with Devon partners:
- ✓ develop a shared control centre for urgent and emergency care to balance pressure and resources across organisations
- ✓ expand use of virtual wards to manage patient care remotely so that more people can stay at home
- ✓ further develop our frailty and fall services to improve outcomes and experience for people
- ✓ implement a Devon-wide waiting list system that will allow organisations to see people more equitably across different areas
- ✓ develop more advice and guidance services associated with patient-initiated follow-ups
- ✓ improve quality of and access to primary care services.

## Quality priority two: achieve sustained improvements against 2022/23 priorities

We recognise that there is more we must do to ensure we sustain current performance and improvement achieved this year around sepsis, deteriorating patient, experience of patient on discharge, falls reduction and risk assessments.

In 2023//24 we will continue our improvement journey against the four quality improvements set out in 2022/23, specifically focusing on:
- ✓ we will roll out the sepsis bundle audit framework across our services and improve compliance within our emergency department, rolling out our new policy in June 2023
- ✓ we will remain focused on the fundamentals of care with a view to improving on the timeless of risk assessments and strengthening the safe bundle to ensure a greater compliance with lying and standing blood pressure
- ✓ we will roll out the early warning score escalation audit across all departments to ensure we are consistently confident that timely and safe escalation takes place when a person’s condition deteriorates.

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## Quality priority three: enhance the experience of people who use our services with focus on leaving hospital

In 2023/24, we will continue to enhance the experience of people who use our services wherever their care may be delivered across acute and community services. This will involve responding to what patients have told us about their care.

In 2022/23, people told us that their care needs to be more personalised. As part of our wider personalisation agenda across we will take steps to ensure that care plans are personalised. We will work with colleagues across health and social care to

ensure a continued focus on care provider quality and the ability of providers yo deliver continually on person centred care following discharge.

There will be a focused improvement program across our care of the elderly wards and we will make better use of the environment to ensure that we are responding to the needs of our most vulnerable and frail patients through a focused program of work around dementia care. This work will be mapped through a newly established ‘care of the elderly, excellence in care group’.

In addition to the priorities set out above, we will continue with our focus on delivery of the national patient safety strategy, ensuring that the role of patient safety leader is rolled out in 2023/24.

## MONITORING AND REPORTING PROGRESS

The quality of our services is monitored through a rigorous reporting framework that provides structure and a regular timescale to the professional approach and cultural values that are lived in our organisation each day.

Day-to-day quality standards and issues that arise are overseen through the following hierarchy:

- ✓ our Board of Directors, with our Chief Nurse as the accountable individual
- ✓ quality assurance committee
- ✓ quality improvement group
- ✓ integrated governance group for each of our six integrated service units (ISUs)
- ✓ associate directors of nursing and professional practice have delegated responsibility for quality within ISUs.

In support of this annual quality report, quality is a major part of our monthly board report and features in monthly reports for each of the above groups.

# 2.2 Statements of Assurance

These statements follow a prescribed form of words legally required by the Healthcare Act 2009, amended 2011.

## Overview of services

During 2022/23 we provided and/or sub-contracted 52 relevant health services. We have reviewed all available data relating to the quality of care in 52 of these services.

## Clinical audit participation

For the Quality Account, the National Advisory Group on Clinical Audit and Enquiries has published a list of national audits and confidential enquiries. Participation in these is seen as a measure of quality of any NHS organisation's clinical audit programme. The detail which follows relates to this list.

During 2022/23, **41** national clinical audits and **three** national confidential enquiries covered relevant health services that we provide.

During this period, we participated in **95**% national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2022/23 follow.

### Participation in national clinical audits and confidential enquiries

| National audits | Eligibility | Participation |
|---|---|---|
| Breast and cosmetic implant registry (BCIR) | Yes | Yes |
| Case mix programme (CMP) | Yes | Yes |
| Child health clinical outcome review (NCEPOD) | Yes | Yes |
| Cleft registry and audit network database | No | N/A |
| Elective surgery (national PROMS programme) | Yes | Yes |
| Emergency medicine QIPs (RCEM) | Yes | Yes |
| Epilepsy 12 | Yes | Yes |
| Falls and fragility fracture audit programme (FFFAP) | Yes | Yes |
| National gastro-intestinal cancer programme | Yes | Yes |
| Inflammatory bowel disease (IBD) audit | Yes | N/P |
| LeDeR – learning from lives and deaths of people with a learning disability and autistic people | Yes | Yes |
| Maternal and newborn infant clinical outcome review programme | Yes | Yes |
| Medical and surgical clinical outcome review programme (NCEPOD) | Yes | Yes |
| Mental health clinical outcome review programme | No | N/A |
| Muscle invasive bladder cancer audit | Yes | Yes |
| National adult diabetes audit | Yes | Yes |
| National asthma and chronic obstructive pulmonary disease (COPD) audit programme | Yes | Yes |
| National audit of breast cancer in older patients (NABCOP) | Yes | Yes |
| National audit of cardiac rehabilitation | Yes | Yes |

| | | |
|---|---|---|
| National audit of cardiovascular disease prevention | No | N/A |
| National audit of care at the end of life (NACEL) | Yes | Yes |
| National audit of dementia | Yes | Yes |
| National audit of pulmonary hypertension | No | N/A |
| National bariatric surgery registry | No | N/A |
| National audit of seizures and epilepsies in children and young people (Epilepsy 12) | Yes | Yes |
| National cardiac arrest audit (NCAA) | Yes | Yes |
| National cardiac audit programme (NCAP) | Yes | Yes |
| National child mortality database | Yes | Yes |
| National clinical audit of psychosis | No | N/A |
| National early inflammatory arthritis audit (NEIAA) | Yes | Yes |
| National emergency laparotomy audit (NELA) | Yes | Yes |
| National joint registry | Yes | Yes |
| National lung cancer audit (NLCA) | Yes | Yes |
| National maternity and perinatal audit | Yes | Yes |
| National neonatal audit programme (NNAP) | Yes | Yes |
| National obesity audit | Yes | Yes |
| National ophthalmology database | Yes | Yes |
| National paediatric diabetes audit (NPDA) | Yes | Yes |
| National perinatal mortality review tool | Yes | Yes |
| National prostate cancer audit (NPCA) | Yes | Yes |
| National vascular registry | Yes | Yes |
| Neurosurgical national audit programme | No | N/A |
| Out of hospital cardiac arrest outcomes registry | No | N/A |
| Paediatric intensive care audit (PICAnet) | No | N/A |
| Prescribing observatory for mental health UK | No | N/A |
| Renal audits | No | N/A |
| Respiratory audits | Yes | N/P |
| Sentinel stroke national audit programme (SSNAP) | Yes | Yes |
| Serious hazards of transfusion scheme (SHOT) | Yes | Yes |
| Society for acute medicine benchmarking audit (SAMBA) | Yes | Yes |
| The trauma audit and research network (TARN) | Yes | Yes |
| UK cystic fibrosis registry | No | N/A |
| UK Parkinson's audit | Yes | Yes |

| Patient outcome programme incorporating national confidential enquires | Eligibility | Participation |
|---|---|---|
| Child health clinical outcome review programme (NCEPOD) | Yes | Yes |
| Maternal and newborn infant clinical outcome review programme (MBBRACE) | Yes | Yes |
| Medical and surgical clinical outcome review programme (NCEPOD) | Yes | Yes |
| Mental health clinical outcome review programme (NCISH) | No | N/A |

## Cases submitted to clinical audits and confidential enquiries

The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| National clinical audit and patient outcome programme incorporating national confidential enquires | Cases submitted | % Cases |
|---|---|---|
| Breast and cosmetic implant registry | N/A | |
| Case mix programme (CMP) | N/A | |
| Elective surgery (national PROMS programme) | N/A | |
| Emergency medicine QIPs (RCEM) | N/A | |
| Epilepsy 12 - national clinical audit of seizures and epilepsies for children and young people | N/A | |
| Falls and fragility fracture audit programme (FFFAP)<br>• national audit of inpatient falls<br>• national hip fracture database | <br>N/A<br>442 | <br><br>100 |
| National gastro-intestinal cancer programme<br>• national oesophago-gastric cancer<br>• national bowel cancer audit | <br>131<br>196 | <br>100<br>100 |
| LeDeR – learning from lives and deaths of people with a learning disability and autistic people | N/A | |
| Maternal and newborn infant clinical outcome review programme | N/A | |
| National adult diabetes audit<br>• national diabetes core audit<br>• national pregnancy in diabetes audit<br>• national diabetes footcare audit<br>• national diabetes in-patient audit – harms | N/A | |
| National asthma and chronic obstructive pulmonary disease (COPD) audit programme<br>• pulmonary rehabilitation – organisational and clinical audit | <br>1 | <br>100 |
| National audit of breast cancer in older patients (NABCOP) | N/A | |
| National audit of cardiac rehabilitation | N/A | |
| National audit of care at the end of life (NACEL) | N/A | |
| National audit of dementia | N/A | |
| National cardiac arrest audit (NCAA) | N/A | |
| National cardiac audit programme (NCAP)<br>• myocardial ischaemia national audit project<br>• national heart failure audit | <br>287<br>397 | <br>100<br>100 |
| National child mortality database | N/A | |
| National early inflammatory arthritis audit (NEIAA) | N/A | |
| National emergency laparotomy audit (NELA) | 147 | 100 |
| National joint registry | | 100 |
| National lung cancer audit (NLCA) | 219 | 100 |
| National maternity and perinatal audit | N/A | |
| National neonatal audit programme (NNAP) | N/A | |
| National ophthalmology database | N/A | |
| National paediatric diabetes audit (NPDA) | 146 | 100 |
| National perinatal mortality review tool | N/A | |
| National prostate cancer audit (NPCA) | 253 | 100 |

| National vascular registry | N/A | |
|---|---|---|
| Sentinel stroke national audit programme (SSNAP) | | 100 |
| Serious hazards of transfusion scheme (SHOT) | N/A | |
| Society for acute medicine benchmarking audit (SAMBA) | N/A | |
| The trauma audit and research network (TARN)<br>1. Clinical Report Issue 1 - Thoracic & abdominal injuries<br>2. Clinical Report Issue 2 - Orthopaedic Injuries<br>3. Clinical Report Issue 3 - Head & Spinal Injuries | <br>632<br><br>476 | <br>100<br>100<br>100 |

| Patient outcome programme incorporating national confidential enquires | Eligibility | Participation |
|---|---|---|
| Child health clinical outcome review programme (NCEPOD) | N/A | |
| Medical and surgical clinical outcome review programme (NCEPOD)<br>1. NCEPOD epilepsy study | <br>4 | <br>75 |

## OUR RESPONSE TO THE FINDINGS OF CLINICAL AUDITS

We reviewed the reports of **30** national clinical audits in 2022/2023 and we intend to take the following actions to improve the quality of healthcare provided:

| Ref | Recommendations / actions |
|---|---|
| **0975** | **(falls and fragility fracture audit programme (FFFAP)) - national hip fracture database** |
| | Less than 90% of patients mobilised day one post-operative<br>An audit was completed in January 2023 to identify reasons why patients were unable to mobilise on day postoperatively.<br>Data of ambulance waiting times was not available as this had never before been recorded.<br>An audit was conducted in December 2022 to ascertain current waiting times for ambulances. |
| **0939** | **(National cardiac audit programme) (MINAP) acute coronary syndrome or acute myocardial infarction** |
| | Review accuracy of the diagnosis of NSTEMI as there may be imprecision in the differentiation between type one and type two myocardial infarction. In order to ensure the completeness and correctness of our data a review of our raw MINAP data is planned. This action was completed in November 2022<br><br>We do not record wire time crossing. For future reference we will therefore record the wire crossing time (WCT), which will improve our figures. We will also look at whole process from arrival at the hospital until wire crossing to enhance our performance. This action was completed in November 2022 |
| **1000** | **(National cardiac audit programme) (MINAP) acute coronary syndrome or acute myocardial infarction** |
| | Door-to-balloon time above national average. Collect and monitor data of door-to-balloon time and use the data and identify and reduce delays by December 2023.<br>Aldosterone antagonists following STEMI with HFrEF<br>Collect and monitor data of aldosterone antagonists usage following STEMI with HFrEF, to identify reasons and increase usage of MRA (Mineralocorticoid receptor antagonists) from current baseline by December 2023. |
| **1004** | **(National cardiac audit programme) heart failure audit** |
| | Collect and monitor data of follow-up arrangements for referrals to cardiology (currently 44.5%)/ specialist heart failure nurse (currently 60.2%) to work towards increasing the referral rate from current baseline by September 2023.<br>Collect and review cardiac rehabilitation (currently 32.1% -) and work towards reducing to national level of 12.1% by September 2023<br>Recruitment of a further heart failure consultant is underway - we are awaiting outcome of funding for a further heart failure specialist nurse and rehab nurse. |
| **1003** | **(National cardiac audit programme) national audit of percutaneous coronary interventions (PCI)** |
| | Non-universal use of intravascular ultrasound (IVUS) for left main stem (LMS) PCI.<br><br>Conduct an audit on use of IVUS on LMS PCI cases and share results with cardiology by 31 August 2024. |

| **0989 (NBACOP) National audit of breast cancer in older patients** |
| --- |
| The reporting of tumour size and Her 2 status is low (and 0% in the over 80 group).<br>The surgical figure for > 80% for ductal carcinoma in situ (DCIS) is given as 0% cf 60% for the rest of country. To be monitored to determine accuracy.<br>No use of bisphosphonates in 80+ age group (cf 24% across other units) and 3% in 50-69 year age group compared with 19% across other trusts.<br>Review of current data as data from NABCOP two years out of date and not in line with current practice. to monitor current practice by 01 February 2023.<br>Use of Her 2 directed chemotherapy was lower in the 80+ age group compared with national average (26% vs 37%).<br>DXT in DCIS post-surgery 39% vs 46% nationally in 70+ age group. This has not been achieved duty to the clinical area not having a designated an audit lead<br>Absence of frailty status and mental capacity score in patients over 70.  All patients over 70 diagnosed with breast cancer to be assessed in clinic/ pre-op assessment – standard operating procedure (SOP) in process of being written. |

| **36 (NCMD) National child mortality database programme - suicide in children and young people** |
|---|
| Review existing national policies and guidance to improve awareness of the possibility of child suicide. Following possible emergency department presentation/ admission to children's ward review existing paediatric liaison standard operating procedures by December 2022.<br>Assess the risk of suicide for children and young people experiencing bullying, when and under what circumstances multiagency meetings to be called to discuss individuals – following possible emergency department presentation/ admission to children's ward making a MASH (Multi Agency Safeguarding Team) referral by December 2022.Review local policies on information sharing and escalation to ensure children and young people at risk of suicide can be identified and supported - following possible emergency department presentation/ admission to children's ward review existing paediatric liaison standard operating procedures.<br>Revised guidance to schools on the use of exclusion risking fracture of relationships with universal services - education's notification to public health nursing. |
| **1005 (NCMD) National child mortality database programme** |
| Non-joint agency response cases, trust to have single point of contact to liaise with bereaved families. To identify clinical professional to act as single point of contact to liaise with bereaved families whilst investigations including internal reviews are carried out and to explain CDOP (child death overview panel) processes by January 2023. This has now been completed Following CDRMs (child death review meeting) at tertiary hospitals, analysis and actions completed during meeting to be shared for local learning.<br><br>On notification of a CDRM date from tertiary hospital child death review coordinator would inform tertiary hospital of professionals involved including social care and request tertiary by January 2023. This has now been completed.<br>Child death review coordinator to share final paperwork from CDRM for local learning, chase if necessary post meeting by January 2023. This has now been completed. |
| **1007 (NEIAA) National early inflammatory arthritis audit** |
| Insufficient patient recruitment into audit. Implement systems to improve data uploading on the audit webpage by 30 April 2023.<br><br>This may require dedicated staff to chase and upload data, including follow-up date for recruited patients. This remains ongoing. |
| **0905 (NNAP) National neonatal audit programme** |
| Improve breastfeeding rates at discharge by 01 December 2022.<br><br>This is now complete and latest data demonstrates that there has been an increase noted in breast feeding rates on discharge. |
| **1012 (NNAP) National neonatal audit programme** |
| Optimal cord clamping - re-launch optimal cord clamping through induction of middle grade and paediatric doctors and improve compliance by 01 April 2023.<br>Simulation of multi-disciplinary team optimal cord care. This plan is now completed. |
| **0941 (NPDA) National paediatrics diabetes audit - spotlight audit report on type 2 diabetes** |
| Review current pathway to ensure all parts of the process contribute towards supporting positive patient outcomes within diabetic and psychology resources currently available by 31 October 2022. This is now completed. |
| **0750 (RCEM) Fractured neck of femur** |

Implement the Abbey pain tool by conducting presentations, displaying posters to triage to the nursing and medical team by 30 April 2023
Collect and analyse data for Fascia Iliaca block and effectiveness of pain management by 31 January 2023.
Conduct and complete an audit regarding time to x-ray for all ?fractured neck of femur. cases by 30 June 2023.

**0751 (RCEM) Pain in children**

Complete a local re-audit to monitor current compliance of pain management in children by 30 April 2023. This remains ongoing.

**0877 (SAMBA) Society for acute medicine benchmarking audit**

SAMBA gives us snapshot data from 24 hours only. We still have no real time data to allow us to benchmark our performance over the other 364 days in the year.
We have been asking for this data for at least three years but our systems have not supported its collection. Ongoing meetings between acute medicine team and performance department in order to create a dashboard/ interactive performance report which we can interrogate on a weekly or monthly basis. Once we have better data, we can identify our performance issues more accurately and decide what action is required to improve performance.

| **1037 (SHOT) Serious hazards of transfusion: UK national haemovigilance scheme** |
|---|
| To increase number of trained staff who are involved in reviewing and investigating blood transfusion related incidents by 31 December 2023.<br>Review local training to ensure a comprehensive training package to include inclusion of indications for use of emergency Group O red cells current, transfusion essential for paediatric patients and appropriate rates of infusion by December 2023.<br>Review current staff who authorise paediatric transfusions to ensure they are appropriately trained by December 2023. |
| **1026 (SSNAP) Stroke care - sentinel stroke national audit programme - mimic audit 2021 short report**<br>**0704 (SSNAP) Stroke care - SSNAP - organisational**<br>**0948 (SSNAP) Stroke care - SSNAP - post-acute organisational**<br>**0729 (SSNAP) Stroke care - sixth SSNAP annual report**<br>**0914 (SSNAP) Stroke care - eighth SSNAP annual report**<br>**1025 (SSNAP) Stroke care - SSNAP - acute organisational audit** |
| Full/detailed action plan embedded below. |
| **0964 National asthma and COPD audit programme (NACAP) - child and young person asthma organisational audit** |
| Review respiratory nurse specialist requirements and current nursing expertise available within service in the team by 02 August 2023. |
| **0992 National audit of care at the end of life (NACEL)** |
| Quality improvement project initiated to review staff confidence in talking to patients and families about the risks and benefits of food and fluids at the end of life<br>Complete audit of notes of patients on end of life care plans to identify whether conversations had. Online Torbay junior doctor survey conducted to ascertain their views and concerns in end of life care.<br><br>Both completed by October 2022. |
| **0982 National diabetes audit programme - national diabetes foot care audit** |
| Face to face education workshop for primary care staff to be developed by February 2023. Action is now completed. |
| **0875 National gastro-intestinal cancer programme - bowel cancer** |
| CNS (clinical nurse specialist) business case - submit business case for additional CNS support.<br>workforce planning.<br>Meeting with two-week wait numbers, cancer operation numbers, waiting list numbers. |
| **0976 National gastro-intestinal cancer programme – bowel cancer** |
| Workforce - clinical nurse specialist (CNS) current funded workforce is unable to meet the required level of service. To prepare a business case for submission to secure funding to recruit additional CNS by 30 September 2022. |

| |
|---|
| MMR/ MSI sent at diagnosis.<br>Ensure biopsies are sent and recorded.<br>Undertake an audit to review compliance of genetic tumour profiling for all patients with stage IV disease by 30 September 2022. Plan is ongoing. |
| **0876 National gastro-intestinal cancer programme - oesophago-gastric cancer** |
| Request for increased resource and support for accurate data submission including prospective clinician validation of the data.<br>Higher than average rate of diagnosis after an emergency admission.<br>Examine performance against an area with similar demographics and consider targeted intervention to reduce rates of emergency admission by 30 November 2022.<br>Lower than average rates of curative treatment offered to patients with stage 0-3 disease.<br>Audit patients with stage 0-3 disease to determine which patients are being offered curative treatment and the drivers for this by 30 November 2023. |
| **0959 NPDA (RCPH national paediatric diabetes audit)** |
| Reduce the number of Children and Young People with HbA1c greater than 80mmol/mol by 25 April 2023.<br><br>Develop a package of enhanced care and support for those with HbA1c greater than 80mmol/mol by 25 April 2023. |
| **0925 Rapid diagnostic services - bladder pathway** |
| Improvement in two-week wait time to be first seen. Re-audit by 31 December 2022<br>Improvement in % hitting 28-day target to TURBT (trans urethral resection of bladder tumour) - Re-audit by 31 December 2022. |

Action plans provided for context:

- ND1037 - (SHOT) Serious hazards of transfusion: UK national haemovigilance scheme.
- (SSNAP) Stroke care - sentinel stroke national audit programme – ND0948 refers to all of the above stroke action plans.

We reviewed the reports of **three** national confidential enquiries in 2022/2023 and intend to take the following actions to improve the quality of healthcare provided.

| **0942 (MBRRACE-UK) - Saving lives, improving mothers care - core report: lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19** |
|---|
| Complete an audit of previous cancer cases of active and prior cancers of all types to check compliance with OM Care and MDT, including timing of appointments by 30 September 2022. Update pending.<br>Undertake an audit/quality improvement for contraception advice for women of child bearing age with cancer.<br>Review/ create radiology imaging in pregnancy guidance.<br>Review admission under other specialities pathway - to include red flags (not just cancer ones) and signpost RCP 15 document.<br>Red flag symptoms and signs added to junior inductions ready for August 2022 intake.<br>Departmental teaching on red flags - plan session and make part of curriculum for each rotation. |

| |
|---|
| Discuss with medical teaching to see if a session is planned this year for core medical trainees. Update presentation to ensure red flags included. |
| **0611 (NCEPOD) Bowel obstruction study** |
| Timely access to a CEPOD list or have/ produce a dedicated general surgery emergency list by 01 February 2023. This is ongoing. |
| **0608 MBRRACE-UK perinatal confidential enquiry - stillbirths and neonatal deaths in twin pregnancies** |
| Update local guidance on multiple pregnancies to include learning from MBRRACE report by 30 June 2023. |

We reviewed the reports of **48** local clinical audits in 2022/23 and we intend to take the following actions to improve the quality of healthcare provided.

| Ref Recommendations / actions |
|---|
| **6073 Recording clinical evaluations and patient dose for Ionising radiation (medical exposure) regulations (IR(ME)R) for endoscopy (2021)** |
| Clinical evaluations: decision to use radiology information system (CRIS) or endoscopy management system (EMS) needs to be made.<br>Staff reminded of the importance of cancelling an episode on CRIS if it has not taken place.<br>Consultants reminded about recording the screening time, dose, dose type and formal report. |
| **6625 Improving the frequency and accuracy of preoperative radiographic markers (templating) for neck of femur fractures** |
| Poster template for marker placement to be introduced in x-ray rooms.<br>Reiterate the importance of templating for hemiarthroplasties during meeting<br>Raise awareness with radiographers to ensure they capture enough of the shaft on the views<br>Demonstrate to colleagues how to use acetates or 'orthaview' to improve compliance with saving templating through education session |
| **6646 Venous thromboembolism (VTE) assessment and prescription in surgical patients** |
| Present to general surgery morbidity and mortality (M&M) for discussion and reminder of requirements<br>Discussion at Band 7 nurses meeting to highlight findings and encourage nursing staff to engage with/ remind doctors of requirements on the ward. Ward audits will now include prescriptions as well as assessments.<br>Presentation at new surgical doctor's induction to highlight results and remind of requirements.<br>Alteration of the surgical ward round proforma document to include a VTE checkbox. |
| **6656 Tonsillitis pathway** |
| Present results to emergency department and offer/ provide training as necessary.<br>Distribute new management workflow process around the department. |
| **6657 Fluoroscopy guided musculoskeletal (MSK) intervention consent** |
| The lead MSK consultant to discuss the results with all physicians<br>The MSK practitioners who scored well below the expected 95% written consent score were given a reminder on ensuring that the consent forms are to be correctly completed in the future. |

| **6660 Time to triage for babies under six months attending emergency department** |
|---|
| Promote documentation of gestational age to reception staff via poster<br>To make a simple additional question on Symphony if any child less than six months books in – ask whether they were premature or in SCBU so that they are then flagged. |
| **6682 Consenting for head and neck skin cancer surgery** |
| Produce a 'bespoke' consent. |
| **6683 Oral and maxillo-facial surgery inpatient record keeping** |
| Implementation of an ‘inpatient note keeping/ recording’ example in the dental core trainee handbook to understand key areas required for notes to meet standard<br>Implementation of ‘roles’ on ward rounds in order to streamline note taking process with greater focus on content.<br>Clinician stamps for junior colleagues; containing name in capitals, GDC number and designation. |
| **6684 Management of gallbladder polyps** |
| There needs to be discussion across the department regarding;<br>- confirming a consensus for approach and<br>- consideration of the creation of a Torbay and South Devon local guideline or distribution of the national ESGAR guideline<br>This has not successfully produced a consensus so audit mark project as 'not for re-audit'. |
| **6700 Breast pain clinic** |
| Healthcare innovations: to assess, on a regional level, short MDT videos and breast pain leaflets to raise awareness with GPs<br>Investigate providing GP teaching sessions for breast pain and family history clinics, also promote GP champions in each practice. |
| **6710 Adherence to alcohol withdrawal management plans** |
| Alcohol withdrawal management policy to be re-written |
| **6711 Post natal contraception counselling and prescribing** |
| Commence a quality improvement project to look at increasing contraception counselling, to include a staff survey to assess current staff knowledge<br>Look to introduce a new patient group direction (PGD) for midwives to be able to prescribe the mini pill. |
| **6712 Effectiveness of referral and referral outcomes to the preterm birth clinic** |
| Introduction of risk assessment for preterm birth (as a proforma to be built into ‘SystmOne’) for all women at their booking appointment<br>Review administration process for referrals to preterm birth clinic for appropriate women. |
| **6713 Assessment of care provided to pregnant women with moderate and high risk for growth restriction** |
| Review small gestational age policy to include recommendations from saving babies lives 2, including a revised scanning schedule<br>Presentation to be shared with all midwives at maternity services meeting<br>Take to clinical governance meeting<br>Explore the need for a business case to train sonographers for uterine artery doppler scanning |

| Consider update to 'SystemOne' re hypertensive disease wording (re decision to restrict the classification looking at previous pre-eclampsia or gestational hypertension with small baby, rather than all with previous hypertensive disorders). |
|---|
| **6714 Learning from COVID-related maternal deaths** |
| Agreement that all women who are symptomatic with COVID need to be seen daily by a consultant (not asymptomatic screen positive).<br>Disseminate requirements for consultant review.<br>Disseminate results to raise awareness of VTE requirements and oxygen saturation on admission (or diagnosis if detected on screening). |
| **6715 Ankle fracture management using orthopathways (OP) in Newton Abbot Minor Injuries Unit (MIU)** |
| Agreement made to trial OP in Newton Abbot MIU |
| **6717 Management of prosthetic joint infection in knee replacements** |
| Need to standardise local management pathway - staff to contact lead knee consultants for local MDT.<br>Education of local team members for local management pathway and national guideline.<br>Complex cases should be discussed in South West Regional Knee MDT - new regional MDT forms needed for communication.<br>Review complex cases to determine why so many are not being discussed with regional MDT, clarify if they were true complex cases.<br>Ensure 'low markers' are audited. |
| **6720 Head and neck skin cancer record keeping** |
| Discuss/ Share results with relevant/ involved clinicians.<br>Design and trial/ pilot a record keeping pro-forma for new skin cancer patients.<br>Adjust pro-forma post trial/ pilot (interim measure).<br>Introduce final version of pro-forma.<br>Complete pro-forma registration/ review with health records committee. |
| **6723 WHO surgical checklist** |
| Assemble a multidisciplinary working group to look at the five parts of the WHO checklist.<br>Relaunch WHO checklist once reviewed and updated by working group.<br>Present audit findings to other speciality meetings. |
| **6725 Shoulder x-rays (XR) and follow up within Paignton musculoskeletal (MSK) physiotherapy clinic** |
| MSK team agreed best practice is to continue to insist that the patient is going for an XR, the patient needs to touch base with us post imaging.<br>Emphasis for physio to insist to patient to book in via booking team with physio post XR. |
| **6729 'Are we meeting national standards for consultant-led care of gynaecology inpatients?'** |
| Move to portal 2 for handover to allow increased functionality. |
| **6733 Venous Thromboembolism (VTE) assessment in trauma admissions** |
| Complete roll out of clinical portal (CP) 2.0 features – VTE risk assessment boxes to appear on |

| handover sheets.<br>Education within department highlighting need for VTE assessments and new prompt box on CP handover sheets.<br>To re-introduce yellow ward sheets. |
|---|
| **6736 Anaesthesia record keeping** |
| Introduction of 'red top' inpatient anaesthetic charts to be the standard method of pre-operative assessment in day surgery |
| **6737 Evaluating whether heart failure patients with reduced ejection fraction and iron deficiency are being adequately managed with iron infusions** |
| Produce management of iron deficiency poster for in patient areas |
| **6741 Time to clinical review and treatment of nasal fractures** |
| Look into causes for delayed referral to e-clinic for nasal fracture<br>Produce, publish and introduce a nasal fracture leaflet for emergency department presentations |
| **6746 Smoking cessation identification and prescribing** |
| Teaching session to be delivered to AMU medical staff regarding Nicotine replacement therapy prescription.<br>Introduction of in-patient smoking cessation service.<br>Change medical patient admission documentation to better document smoking status. |
| **6749 Revision Total Hip Replacements including periprosthetic hip fractures (PPF) multidisciplinary team (MDT) discussions** |
| MDT documentation, especially pertaining to PPF needs improving<br>Develop new database to record MDT discussion/ decisions. |
| **6751 Post-operative venous thromboembolism (VTE) prophylaxis for orthopaedic trauma patients** |
| Introduce new VTE policy for low-molecular-weight heparins while inpatient, followed by oral Rivaroxaban 10mg once a day (OD) on discharge. |
| **6758 Dysphagia care plan compliance** |
| Ward based catering staff to take on role of thickening drinks – thickener tubs can then remain on the drinks trolley not tables and drinks are correct at the point of delivery improving standards.<br>Dysphagia e-Learning programme undertaken by (average) of 70% of ward staff across in-patients.<br>Flowchart for appropriate spout usage alongside raising awareness of dangers/ downsides of widespread spout usage. |
| **6761 Assisted vaginal birth – 2020** |
| Feedback re removal of catheters first thing in the morning rather than after 12 hours.<br>Reminder to document trial without catheter (TWOC) timing, first pass urine and volume passed. |
| **6767 Aspirin prescribing in high risk pregnancy** |
| Women who need to see a specific consultant to be booked for their first trimester screening clinic (FTSC) scan before 13 weeks. This will allow prescription of aspirin at the optimum time |

and a separate consultant appointment can be booked if unable to schedule at the same time.

**6768 Management of diabetes ketoacidosis (DKA) on Forrest ward**

Undertake junior doctor and nurse teaching on Forrest ward regarding fluid prescription and venous blood gas, boehringer mannheim (BM) and ketones as recommended by our guidelines.
Diabetes specialist nurses have provided some teaching to emergency department nurses regarding DKA.
To provide teaching to junior doctor teaching on acute medicine.
New proposed ideas about modifying fluid charts for DKA (adding long acting insulin prescription box, adding 10% glucose prescriptions if BM< 14 etc).

**6675 Lymphoedema patients having a second appointment within one month of their first assessment**

Take to internal MDT to brainstorm ideas to improve this outcome and find a way forward for the service.

**6765 CX3 (highly suggestive of lung cancer) chest x-ray (CXR) code compliance**

Staff reminded about usage of CX3 code in radiology audit meeting

**6721 Intravenous (IV) methylprednisolone for patients with giant cell arteritis (GCA)**

Creation of a clear guideline for staff to follow when booking patients in for IV methylprednisolone.
To have a consistent method of informing the GP about the infusions. Introduce a universal form that can be filled in by nursing staff after completion of treatment in both TAIRU and by MAAT.
Liaise with TAIRU and MAAT team about the current process to identify why TAIRU have difficulty fitting in patients for methylprednisolone infusion.
To improve patient sample number for future audits, we will start to record using the biologic tracker on Infoflex.

**6726 Venous Thromboembolism (VTE) prophylaxis for Turner Ward**

Encourage VTE documentation during board rounds?
Investigate e-Learning module on VTE prophylaxis?
Investigate changes to the prescription chart i.e.

- keeping VTE risk assessment (RA) on the front page(s) may improve VTE RA uptake on the admission as well as recording at 24 hours
- moving the time of administering thromboprophylaxis (Fragmin) to the mid-day can allow nurses discussing with junior doctors if VTE RA is not recorded.

**6704 Enteral feeding of infants**

Ensure a growth chart is in the notes from admission, and for this to become a part of an ‘admission pack’.
Reinforce the weekly routine whereby babies have routine blood tests on a Tuesday and the Wednesday ward round has nutrition emphasis. Babies should be plotted by medical team weekly and discuss any concerns with a dietitian.
A laminated weekly ward round routine to be placed in special care baby unit (SCBU).
Review enteral feeding guideline to make advice on formula and nutritional supplements clear.
Categorise the babies according to traffic light system and collect the data and type of milk according to that.
Reinforce documentation of breastfeeding advice was given, including the babies admitted to SCBU even on intravenous (IV) fluids.

| |
|---|
| **6730 Juvenile idiopathic arthritis (JIA): joint injection to physiotherapy** |
| Commence MDT clinic with paediatric physiotherapy involvement. |
| **6716 Management of progesterone-only-implants within Torbay Devon Sexual Health Service** |
| During meeting all clinicians were advised of the MHRA reporting scheme and how to access it to report deep/ broken implants.<br>Re-write implant template – currently there are five different templates – aim to reduce template for counselling/ fit/ follow up.<br>Once the new template has been produced, discuss at contraception meeting.<br>Documentation of standard fit site – this will be built into new template with space to document if fitted at alternate site with reason why.<br>Pregnancy testing at baseline – discuss at contraception meeting what we want to aim for since this point is debatable and practice may differ. |
| **The following audits were reviewed during the year but did not require an action plan:** |
| 6666 Assessment of outcomes of meta-tarsal joint (MTPJ) fusions<br>6672 Review of breast cancer screening assessment against national breast screening standards (NBSS)<br>6719 Symptomatic breast imaging protocol (2020)<br>6722 Paediatric coeliac disease service<br>6724 Induction of labour (IOL): vaginal birth after caesarean (VBAC) and second option<br>6727 Are plain abdominal x-ray (AXR) clinical details in line with best practice guidelines?<br>6728 Secondary intraocular lens (IOL) outcomes<br>6740 Clinical appropriateness for referral to the emergency ENT clinic<br>6747 Bladder complications following day-case prolapse procedures. |

## RESEARCH

The number of patients receiving relevant health services provided or sub-contracted us in 2022/23 that were recruited during that period to participate in research approved by the NHS Ethics / Health Research Authority (HRA) was 2,476.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Through active participation in research our clinical staff stay abreast of the latest possible treatments and leads to improved patient outcomes.

## Care Quality Commission (CQC)

We are required to register with the Care Quality Commission (CQC) to provide care and our current registration is to be able to deliver the following regulated activities:

- ✓ 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.

We have no conditions or restrictions attached to our registration.

During the reporting period 2022/23, we had no formal CQC inspections but continued to work in partnership with the CQC via our regular planned contact. This scheduled activity includes our monthly CQC meetings with our local inspector and inspection manager as well as the quarterly engagement meetings. These meetings have executive involvement and are a good vehicle for open discussion and sharing between ourselves and the CQC.

We also continued our audit and assurance work to ensure risk assessments were completed for each patient within 24 hours of admission to hospital and in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken.

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an integrated service unit (ISU) level, as well as at the nutritional steering group and by exception to the quality improvement group.

Our current CQC ratings are shown in the table below:

Our current full ratings, including the core services ratings from the last inspections, can be found on the CQC's website: https://www.cqc.org.uk/provider/RA9.

We have not participated in any special reviews or investigations by the CQC during the 2022/23 reporting period.

## DATA QUALITY AND INFORMATION GOVERNANCE

We submitted records during 2022/23 to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- ✓ for admitted patient care – 99.9%
- ✓ for outpatient care – 100.0%
- ✓ for accident and emergency care – 99.5%.

The percentage of records in the published data which included the patient's valid general medical practice code was:

- ✓ for admitted patient care – 98.2%
- ✓ for outpatient care – 97.2%
- ✓ for accident and emergency care – 97.4%.

The data security and protection toolkit is an online self-assessment tool that allows organisations to measure their performance against the national data guardian's ten data security standards. All standards were met in 2022/23.

## PAYMENT BY RESULTS CLINICAL CODING AUDIT

We have not been in receipt of a payment by results clinical coding audit by the Audit Commission. Instead, an annual data security protection toolkit audit of clinical coding has been completed. The audit was completed by an NHS Digital approved auditor.

The key results are:

| Primary diagnosis (% correct) | Secondary diagnosis (% correct) | Primary procedure (% correct) | Secondary procedure (% correct) |
|---|---|---|---|
| 92.23 | 70.26 | 93.67 | 93.41 |

# PATIENT MORTALITY

## Learning from patient deaths

Mortality is reviewed each month by a multi-disciplinary team at the mortality surveillance group. A mortality scorecard is presented to the Board of Directors bimonthly by the Medical Director.

We use analysis by Dr Foster to process hospital episode statistics (HES) data directly from NHS Digital to inform the monthly mortality review. The hospital standardised mortality ratio (HSMR) is measured from the mortality arising from a standardised 'basket' of 56 diagnoses.

The HSMR is above the expected level of 100 for our population. The rolling 12-month position exceeded the expected range for the 12-months to December 2022 with a relative risk of 111.5 against a 100 benchmark. The rolling 12- month trend shows that the HSMR became statistically higher than expected in July 2021. The last eight data points have remained stable with a slight downward trend. Our HSMR is one of 11 trusts in our peer comparator which are statistically higher than expected out of 20 trusts. The increase in HSMR over the last two years is broadly in line with the trend of increase in HSMR seen by our similar peers.

The factors affecting HSMR have been considered. We have a lower Charlson co-morbidity of 20+ and overall we report a higher percentage of spells in the 'symptoms and signs' chapter (9.0% v 7.5% national). This may impact by reducing the overall expected mortality rate. We have a greater proportion of patients in the higher deprivation quintiles compared to regional peers. Higher deprivation is known to contribute to poorer health outcomes and shorter life expectancy. Our patients are older than the peer average which might result in a greater number of observed deaths.

The higher than expected HSMR is subject to a mortality improvement plan to consider all aspects which impact on HSMR including coding, patient mix and process of care.

The patient safety team has investigated 30 day mortality in patients admitted as an emergency comparing October 2019 figures with those in October 2022. Elderly and frail emergency patients appear particularly sensitive to the adverse effects of waiting for a definitive in-patient bed.

Focused work continues on provision of alternatives to admission by working with frailty teams in the community and acute hospital and the development of virtual wards

Analysis of the standardised hospital mortality index (SHMI) includes deaths occurring in hospital and up to 30 days after discharge. Our SHMI is 1.03 which is as expected.

Medical Examiners now provide scrutiny of all inpatient deaths in the acute and community hospitals and we are rolling out into the community setting in readiness for the commencement of statutory scrutiny in April 2024.

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. We have created a new LeDeR process which has established close interaction monthly with the regional LeDeR team. A review of the last two years deaths has been undertaken and is summarised in table 7 on the next page.

Table 7 – summary of LeDer referrals

| Year | Review undertaken – o formal diagnosis of LD. Closed with no outcome | Reviews undertaken – closed with outcomes and learning provided | Awaiting LeDeR review outcomes |
|---|---|---|---|
| 2021 / 2022 | 4 | 5 | 5 |
| 2022 / 2023 | 4 | 1 | 7 |

Of the reviews resulting in outcomes [all five] in 2022 / 2023no lapses in care were identified therefor no specific action plans relating to clinical improvements, however dissemination of learning did take place with regard to:

- Use of Patient Passport
- Care and Communication
- Liaison with the LD team
- Personalised Care Plans

## Mortality figures and reporting

| Ref. | Information required | Our response |
|---|---|---|
| 27.1 | The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure. | During 2022/23, 1,456 of our adult patients died in t acute hospital. This includes the Emergency department.<br><br>This comprised the following number of deaths whi occurred in each quarter of that reporting period:<br>• 339 in the first quarter<br>• 308 in the second quarter<br>• 418 in the third quarter<br>• 391 in the fourth quarter. |
| 27.2 | The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure. | During 2022/23, 1406 case record reviews have be carried out by the Medical Examiners in relation to t number of the deaths included above.<br><br>This comprised the following number of case scruti which occurred in each quarter of that reporting per<br>• 297 in the first quarter<br>• 300 in the second quarter<br>• 418 in the third quarter<br>• 391 in the fourth quarter. |
| 27.3 | An estimate of the number of deaths during the reporting period included | During 2022/23, 12 cases for which the outcome was death were reported on the strategic |

| | | |
|---|---|---|
| | in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this. | executive information system (STEIS). All these incidents had reports produced which were communicated to NHS Devon and discussed at our serious adverse event group which meets on a monthly basis. |
| 27.4 | A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. | The themes from learning from death reviews:<br>• focus on anticoagulants on care planning summaries to prevent stroke<br>• recognition of deteriorating patient with sepsis<br>• alcohol withdrawal and myocardial infarction<br>• administration of time critical medication to prevent fitting<br>• risks of patients held in ambulances awaiting admission to ED<br>• diagnosis and treatment of meningo-encephalitis in children<br>• recognition and response to post-operative peritonitis<br>• urosepsis in cystectomy patient with solitary kidney and renal stone – delays in non-cancer urology surgery<br>• recognition of the complications of head injury in alcoholic patients<br>• incarcerated hernia in palliative patient<br>• GI bleed led to fall and death in community hospital due to chronic sub dural<br>• understanding of multi-disciplinary nature of child death process. |
| 27.5 | A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4). | • focus on human factors in verbal and written communication between clinical teams<br>• focus on management of frail and elderly in urgent and emergency care<br>• focus on sepsis and deteriorating patient via appropriate patient safety groups. |
| 27.6 | An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. | • changing focus on patient incident investigation to ensure just culture and thematic review<br>• wider recognition of vulnerability of frail and elderly patients to the effects of prolonged waits urgent and emergency care. |
| 27.7 | The number of case record reviews or investigations finished in the | Zero. |

| | | |
|---|---|---|
| | reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period. | |
| 27.8 | An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this. | Not applicable. |
| 27.9 | A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8. | During 2022/23, 12 cases for which the outcome was death were reported on the strategic executive information system (STEIS). All these incidents had reports produced which were communicated to NHS Devon and discussed at our serious adverse event group which meets on a monthly basis. |

## 2.3 CORE INDICATORS

***Performance in 2022/23***

In addition to reporting performance against the statutory indicators for regulatory assessment a range of further quality indicators are reported to our Board of Directors.

| Other national and local indicators | Quality indicator | Target 2022/23 | 2022/23 | 2021/22 | 2020/21 | 2019/20 |
|---|---|---|---|---|---|---|
| DNA rate* HES data | Effectiveness | 5% | 5.2% | 5.6% | 5.1% | 5.1% |
| Stroke care: 90% of time spent on stroke ward | Effectiveness | 80% | 57.5% | 54.8% | 77.3% | 90.2% |
| Two-hour urgent community response | Effectiveness | 70% | 80% | | | |
| Mixed sex accommodation breaches of standard | Experience | 0 | 0 | 0 | 0 | 0 |
| 52-week referral to treatment incomplete pathways year end position | Experience | 0 | 4427 | 3,199 | 2,049 | 53 |
| Cancelled operations on the day of surgery | Experience | <0.8% | 1.5% | 1.5% | 1.5% | 1.3% |
| Never events | Safety | 0 | 3 | 0 | 4 | 2 |
| Cancer 28-day Faster Diagnosis | Effectiveness | 75% | 70.7% | 67.6% | 75.6% | 74% |
| Diagnostic waits greater than six weeks | Effectiveness | 25% in 22/23 | 31.2% | 34.8% | 42.1% | 11.5% |

## Plans for 2023/24

Looking ahead we have improvement plans to meet the challenges to deliver quality and timely access to our acute and community services. Recovery from the impact of the COVID-19 pandemic continues to see improvements in capacity and activity levels. There remains significant challenges to meet 2023/24 Operating Plan targets to:

- ✓ reduce waiting times for treatment (no patient waiting over 65-weeks)
- ✓ reduce patient delays in the urgent and emergency care setting;
- ✓ reduce long length of stay in acute and community beds;
- ✓ increase the provision of intermediate care to support patient discharge and to help people stay in their homes where appropriate.

In 2023/24, we will continue the work started in 2022/23 to develop one plan that brings together key elements and will focus on:

- ✓ quality and safety for people who use our services and our people
- ✓ cost improvement initiatives – affordability and sustainability
- ✓ innovation and improvement for performance and productivity.

This will require a combination of fully utilising and ensuring efficiency in our estate, engaging with clinicians to improve pathways of care for patients, recruitment to key clinical vacancies, using available investments to ensure our population are receiving better health and care and building on new ways of delivering services including remote consultations and patient-initiated care. We will also work collaboratively with the rest of the integrated care system for Devon to deliver services against a system oversight framework with regular scrutiny and monitoring by NHS England.

# 3 OTHER INFORMATION

## OVERVIEW OF SERVICES AND GOVERNANCE

We are an integrated care organisation. We continue to work with and be accountable to:

- ✓ NHS England and Improvement, our regulator
- ✓ the Care Quality Commission
- ✓ the commissioners via the various health contracts
- ✓ the Local Authorities for social care
- ✓ our local communities through our members and governors.

Our delivery structure in 2022/23 was based on having two population-based operational 'systems' and five integrated service units as follows:

- ✓ Torbay system, comprising:
  - Torquay locality
  - Paignton and Brixham locality
- ✓ South Devon system comprising:
  - Coastal (Teignmouth and Dawlish)
  - Moor to Sea (Ashburton, Bovey Tracey, Totnes and Dartmouth)
  - Newton Abbot

In 2022/23 we commenced a phased programme of work to proactively reshape our structure in response to societal changes, enhancing what works well and developing improved ways to respond to our challenges.

The first phase, completed in 2022/23, was to remove the two population-based systems and introduce three care pathway groups under which our integrated service units sit:

- ✓ Families and communities, comprising:
  - Torquay locality
  - Moor to Sea locality
- ✓ Medicine and emergency care, comprising:
  - Newton Abbot locality
  - Hospital operations team
- ✓ Planned care, comprising:
  - Paignton and Brixham locality
  - Coastal locality.

Our governance process sees our integrated service units hold their teams to account through monthly integrated service unit meetings. The integrated service units report each month into director led care group integrated governance meetings which provides updates on operational delivery and any risks to the executive team at the trust management group.

Our trust Management group then informs the various sub-committees of our Board of Directors of any items for escalation.

# PERFORMANCE AGAINST QUALITY STANDARDS

## National standards

This performance overview provides information about how we have performed against agreed operational objectives during the year.

2022/23 has been a challenging year for us with ongoing recovery from the COVID-19 pandemic. Workforce and estates capacity, along with other factors, resulted in a lower level of clinical activity than planned which impacted on elective performance and saw waiting lists climb. Across urgent and emergency care performance, patient flow was the main operational challenge resulting in increased length of stay and frequently having our emergency department and assessment units at full capacity. The four-hour standard and ambulance handover delays did not meet planned levels of performance.

Along with other providers in Devon, we have experienced long patient waits for referral to treatment and cancer care. Since June 2022, we have been required to comply with Tier 1 performance reporting. Tier 1, being the highest level of regulatory performance oversight.

During the reporting period, monthly performance reports were provided to the finance, performance and digital committee and to our Board of Directors. These reports covered all the Tier 1 and other operational plan performance standards.

The key performance indicators for 2022/23 are shown below:

**Tier 1 monitored standards**

| | Target | 13 month trend | Apr-22 | Jun-22 | Sep-22 | Dec-22 | Mar-23 |
|---|---|---|---|---|---|---|---|
| Tier One oversight performance metrics | | | | | | | |
| RTT 104 week wait incomplete pathway | 0 | | 192 | 96 | 50 | 29 | 0 |
| RTT 78 week wait incomplete pathway | 176 | | 779 | 713 | 813 | 923 | 183 |
| Number of patients waiting longer than 62 days for treatment | 138 | | 245 | 233 | 333 | 253 | 114 |
| Percentage of patients waiting longer than 62 days for treatment | | | 11.8% | 10.2% | 13.6% | 17.1% | 7.0% |

## 4 Hour Emergency Department (ED) waiting times:

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23
% seen within 4 hours
National target

Performance against the four-hour standard in our emergency department in 2022/23 has continued to reflect the challenges of capacity and managing daily patient flow. Long waits have continued to be experienced in the emergency department. Ambulance handover delays have also been high due to the department, at times, reaching capacity.

There has continued to be an impact from managing COVID-19 on hospital capacity and designation of ward beds to meet infection control safeguards. Industrial action from a range of professions during quarter four also affected performance and activity. Working with our colleagues, we developed a robust process to ensure patient safety during periods of industrial action.

Bed capacity has been increased by the opening of the new acute medical unit (AMU) in December 2022 and the discharge lounge has been expanded.

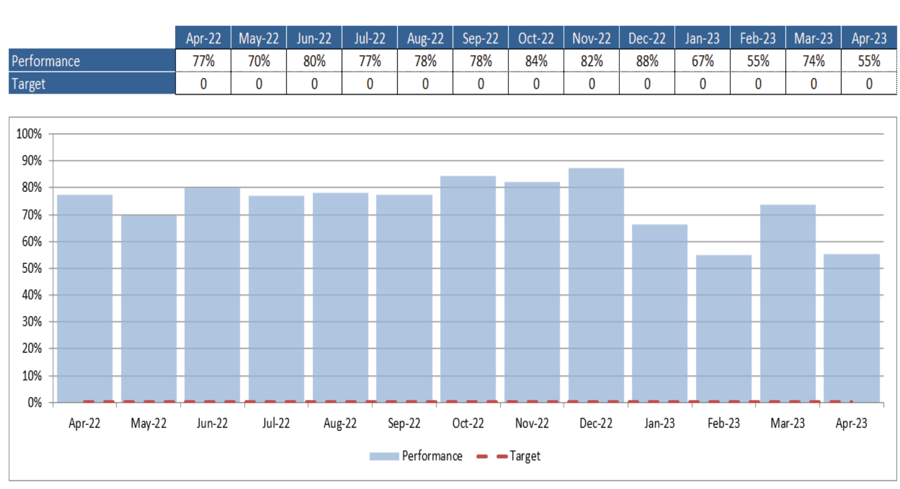
Our improvement actions have focused on increasing the number of daily discharges earlier in the day and at weekends along with reducing the number of patients in hospital with “no criteria to reside”. Progress has been seen with improved planning and daily escalation. The number of patients with no criteria to reside has reduced from a daily average of 48 (13%) in December 2022 to 28 (8%) March 2023. Ambulance handover delays have improved in in the last quarter of the year (Q4 month average of 789 over 30-minute delays compared to 1140 in Q3), however, remain a challenge with further improvement required in 2023/24.

Our plan for 2023/24 is to meet the new national 76% operating plan target against the four-hour performance by March 2024. There are a number of further developments supported by the urgent and emergency care transformation programme to increase effective bed capacity for emergency admissions, patient flow, and pathways within the emergency department.

These plans include:
- ✓ the introduction of virtual ward pathways of care to support people to stay at home where we can safely do so, facilitate earlier discharge from hospital and reduce admissions to ensure beds are available for those most in need on hospital care
- ✓ support for the complex discharge process and the capacity of intermediate

and social care to reduce further the number of ‘no criteria to reside’ to 5%
- ✓ continued focus on timeliness of daily discharges, use of the discharge lounge, and increased number of weekend discharges
- ✓ optimisation of clinical pathways to the new acute medical unit to increase the number of same day emergency care discharges
- ✓ focus on reducing beaches of the four-hour standard for non-admitted pathways of care.
- ✓ streaming patients to alternatives to our emergency department, for example, our urgent treatment centre, minor injury unit, pharmacies and self-care.
- ✓ improving performance at our urgent treatment centre and minor injury unit.

## Ambulance handovers:


Percent of ambulance handovers over 15 minutes

| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Performance | 77% | 70% | 80% | 77% | 78% | 78% | 84% | 82% | 88% | 67% | 55% | 74% | 55% |
| Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |



Ambulance Handover delays were challenging for 2022/2023 particularly in the first three quarters of the year with 70-88% of all arrivals in excess of the 15-minute handover standard. In the last quarter of the year, the opening of our new acute medical unit provided support to patient flow in the hospital.

During the same quarter we placed a key focus on committing to improving the two main causes of patient flow imbalance by improving performance in the following ways:
- ✓ increasing the number of patient discharges before noon
- ✓ increasing the number of patient weekend discharges.

As a result of the above we saw a benefit to patient flow within the hospital and emergency department and as result a positive reduction in handover delays to 55% over 15 minutes in April 2023.

The plan for 2023/34 is to continue to build on the improvements above and through the urgent and emergency care board work towards no ambulance delays at the end of March 2024.

## Referral to Treatment (RTT) access times:

The number of people waiting for treatment increased during the year with 40,180 patients waiting at the end of March 2023 for first definitive treatment, up from 37,261 in March 2022. The number of people waiting over 104 weeks, however, has been reduced to zero in this time and we achieved our Tier 1 improvement trajectory to reduce the number of people waiting over 78 weeks.

Our day surgery unit supports the delivery of national exemplar performance for day case surgery completion rates and productivity. During COVID-19 escalation our day surgery unit was used as escalation space for emergency admission assessment with a consequential impact on day surgery waiting lists. In April 2022, following the completion of the interim medical assessment areas our day surgery unit was fully restored to elective use. This has enabled teams to increase the number of day case procedures undertaken and start to reduce the number of people waiting for day case procedures.

In 2022/23 we worked closely with system partners to make use of allocated capacity at the former Nightingale Hospital in Exeter recommissioned to provide elective orthopedic short stay procedures and diagnostic hub. In 2023/24 this allocation of capacity will be increased with cataract procedures taking place at the Nightingale.

In the outpatient setting of care, challenges have been seen with increases in waiting times for outpatient appointments and outpatient treatments. Through a focus on outpatient productivity, including pathways to utilise virtual non-face to face appointments and managing follow up pathways to release capacity, performance has started to improve. Work continues to support patient capacity and productivity through the outpatient service transformation programme and insourcing of additional clinical capacity in the most challenged areas.

The plans for 2023/24 are to have no patient waiting over 65 weeks. These plans are reliant on recruitment to vacant posts, sourcing of additional capacity and system mutual aid. We have successfully bid to increase day surgery and endoscopy theatre capacity with two additional day surgery theatres and an additional endoscopy suite scheduled for completion by the end of 2023/24.

### Referral to treatment 65 week wait Tier 1 monitoring and trajectory

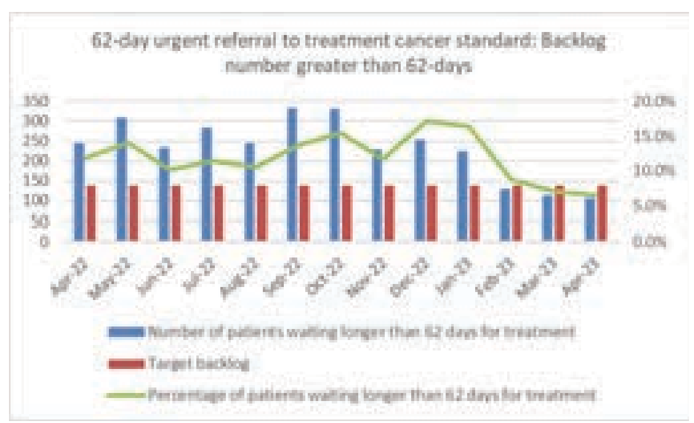
| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 65wk Trajectory | 1292 | 1362 | 1312 | 1200 | 1300 | 1100 | 840 | 710 | 600 | 400 | 200 | 0 |
| Actual | 1220 | 1168 | 1220 | | | | | | | | | |

## Cancer standards:

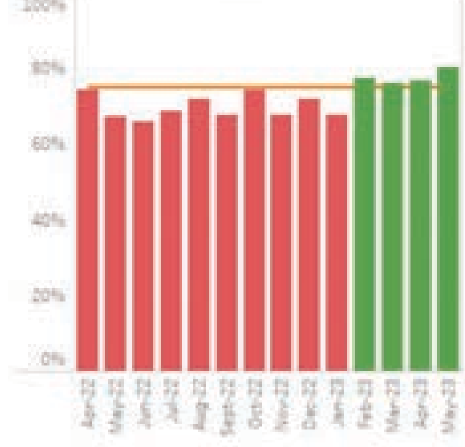
We maintained our commitment to prioritise delivery of cancer treatments. However, we entered Tier 1 performance monitoring by NHS England due to the increasing number of people waiting beyond 62 days for treatment following urgent referral. Since November 2022 there has been steady improvement with the backlog reduction meeting the threshold for stepping down out of Tier 1. This number reduced from 333 patients in November 2022 (13.6% of total list) to 114 patients (7% of total list) by end of March 2023.

Over the year we have not consistently met the 14-day urgent referral to be seen, nor 28-day from urgent referral to diagnosis standards. There are known challenges and risks. However, close monitoring is in place with action plans reviewed through cancer performance oversight. In March 2023 we achieved 77.4% against the 28-day referral to diagnosis standard (target 75%) and 76% against the 2ww standard (target 93%).

### Over 62-day referral to treatment standard: greater than 62-day backlog (open pathways)




### Faster diagnosis 28-days from referral cancer standard




## Diagnostics:

Demands for diagnostic tests has continued to increase. The delivery of required levels of capacity in CT and MRI is dependent upon the sourcing of additional capacity using mobile units. We will commission a new Radiotherapy Planning CT scanner at Torbay which will be operational by September 2023 and will strengthen our clinical oncology pathways. People in Torbay and South Devon continue to benefit from additional CT and MRI capacity at the Nightingale Hospital Exeter.

Recruiting to staff vacancies across the major diagnostic specialties remained a challenge throughout the year.

Endoscopy services has used additionally sourced weekend capacity throughout the year to stabilise waiting lists along with additional mobile capacity to support waiting list initiatives in preparation to the estates works to create additional facilities that will impact for a period in 2023/24.

### Diagnostic greater than 6-week wait breaches as a percentage of total waits

### Equality of service delivery:

We maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting patients by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact with patients is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should a patient’s condition change or they fail to engage with offered appointments.

The Devon System is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital Exeter as a system resource to support additional capacity for diagnostics, orthopaedic, and ophthalmology treatments.

### Assurance and performance monitoring:

Weekly assurance meetings are held with operational leads and the system care group directors reporting to the Chief Operating Officer.

These meetings are in addition to the monthly integrated service unit (ISU),

executive-led, integrated governance group (IGG) meetings where performance is reviewed with system leadership teams following each ISU's monthly governance process.

For 2023/24, monthly urgent care and planned care board meetings have been established to track the delivery of transformation programme and performance against agreed plans.

This process gives the executive team and our Board of Directors assurance in relation to performance monitoring including escalation of performance risks where additional support is needed and actions being taken.

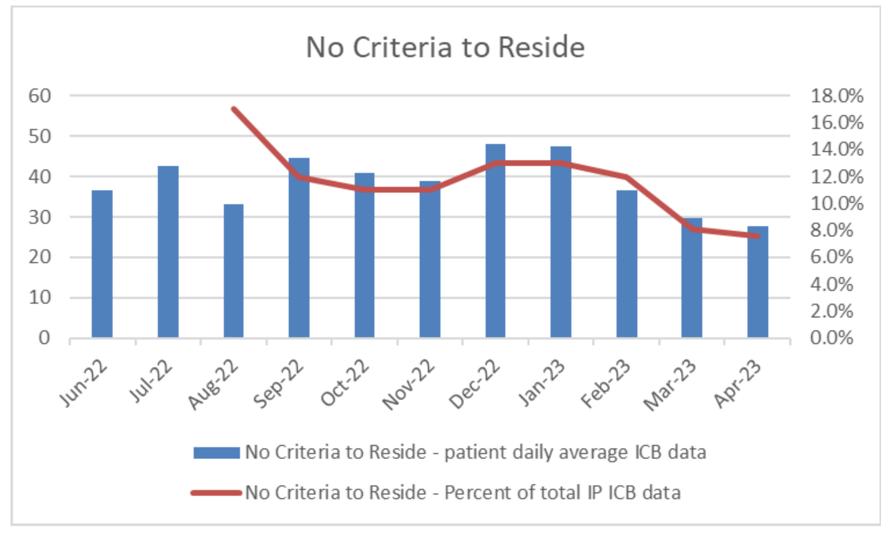
## Other areas of performance to note

### No criteria to reside

This is the status of a person who (having undergone appropriate treatment and assessment) no longer meets a medical criteria to stay in an acute or community hospital bed. Patients who are identified as having no criteria to reside were previously known as a delayed discharge.

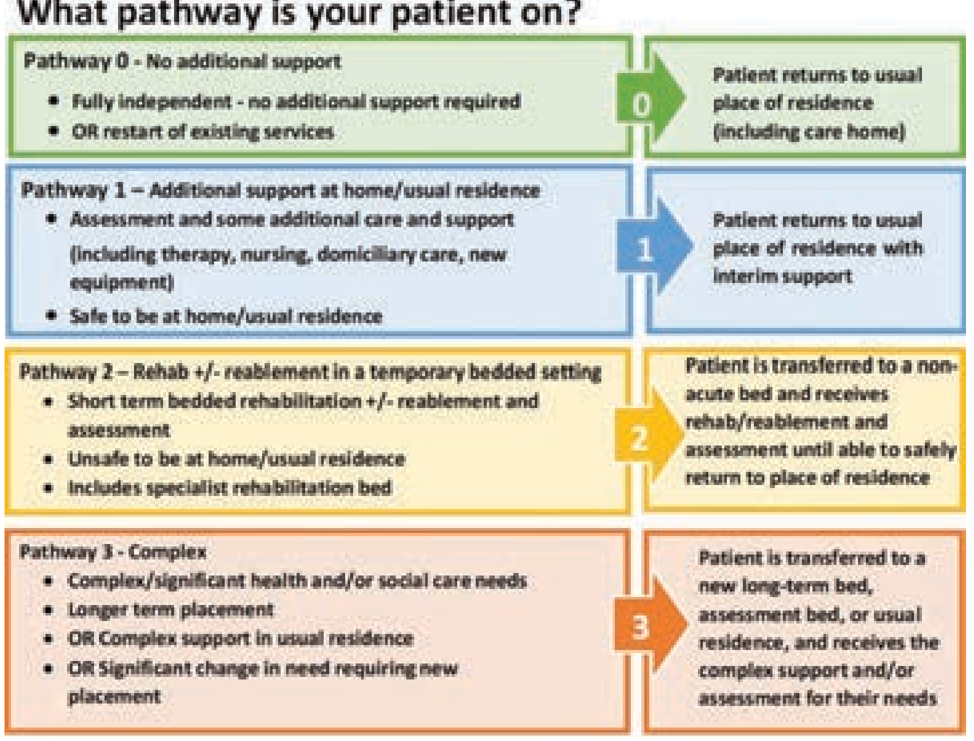
A person occupying a hospital bed with no criteria to reside is potentially occupying a bed space needed for people requiring admission from our emergency department, assessment units or transfer into a community hospital. This has contributed to delays in our emergency department and ambulance handover delays as full capacity is reached.

For these reasons we have implemented an improvement programme supported with funding to remove any process delays in discharge and increase capacity, particularly for the more complex discharges where other care packages or intermediate care support is needed.



During the year the number of beds occupied in the acute and community hospitals with no criteria to reside has improved from over 13% of beds occupied to 8% in March and 7.5% in April 2023. The recovery target set for improvement for no criteria to reside is 5% for 2023/24.

## Complex pathway discharges:




The total number of people discharged through pathways one to three has remained fairly consistent throughout most of the year, averaging 251 complex pathway discharges per month. Pathways one to three are considered ‘complex’ as patients require support to enable a safe discharge.

During December the number of people on pathway two who could be discharged decreased. There was also an increase of COVID-19 cases which led to ward closures and care homes adhering to the guidelines for admission.

Throughout early January, providers began to accept new referrals again, and additional block contracted beds were purchased to support discharge into temporary bedded placement. This resulted in a year high for pathway two discharges and a total of 297 complex pathway discharges for January.

Across the 12 months the following numbers of patients were discharged on each pathway

| Pathway | % | Actual |
|---|---|---|
| One | 56.65 | 1,704 |
| Two | 35.01 | 1,053 |
| Three | 8.34 | 251 |

### Average length of stay

The average length of stay in 2022/23 has increased however this remains in line with other provider trusts in the south west.

In 2022/23 the average length of stay for patients admitted as an emergency and staying overnight was 7.9 days and this compares to 7.6 days average across other provider trusts in the south west. Infection issues, specifically COVID-19, have contributed to this increase length of stay.

Moving into 2023/24 reducing length of stay remains an ongoing key focus for us to support both elective and non-elective activity and as such has been recognised in improvement plans specifically centered on early morning discharge, discharges before 5pm and at the weekend.

### Stroke care

Patients presenting with suspected stroke require rapid assessment diagnostics and dedicated rehabilitation care. The sentinel stroke national audit programme (SSNAP) measures the time critical processes of care provided across acute and community settings.

We did not meet the standards for the percentage of patients admitted to a stroke unit within four-hours of arrival or the percentage of patients spending 90% or more of their hospital stay on a dedicated stroke ward. We have a stroke improvement plan to support patient outcomes and achievement of time critical standards. This plan is managed through the clinically led stroke governance meeting.

### Winter planning 2022/23

We improved our operational resilience heading into winter with an understanding that COVID-19 and general winter pressures would be challenging and there would be an ongoing need to clinically risk management patients and importantly support the ongoing work to improve ambulance handovers and response times.

In conjunction with Devon system wide partners we focused on the following key themes of improvement:

- ✓ establishing a winter control room to support daily operational challenges
- ✓ better support for people in the community
- ✓ delivering on our ambitions to maximise bed capacity and support ambulance services

- ✓ ensure timely discharge and support people to leave hospital when clinically appropriate.

Key areas of support that helped maintain the resilience during the winter period were the continuation of eleven emergency department escalation beds, the expansion of the discharge lounge, opening of the new acute medical unit and maintaining McCullum ward for winter escalation. Community support in the form of additional care home placements and packages of care likewise contributed to resilience.

## Maternity performance 2022/23

Maternity assurance metrics are based on recommendations to meet the national priorities to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025.They are also based on the requirements set out in the maternity incentive scheme (MIS) as part of the clinical negligence scheme for the trust (CNST) as well as those recommendations from both Ockenden and East Kent Hospital's reports.

A monthly dashboard is produced which is monitored via maternity governance group. Metrics are shared via quality assurance groups within the organisation. An integrated performance report is shared at the monthly Board of Directors meetings.

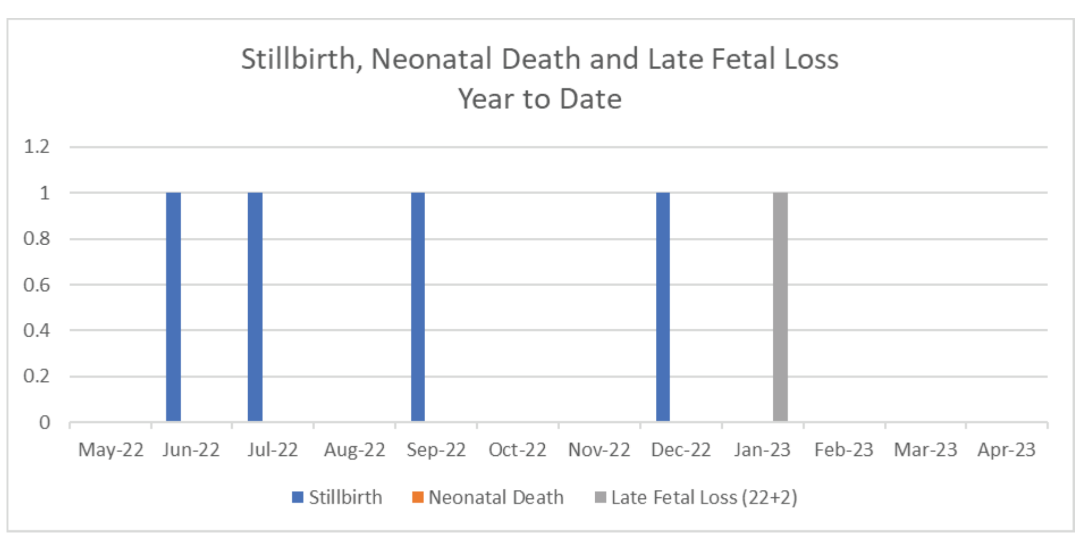
## Birth rate

The number of births for 2022/23 was 1,847. This is a reduction from 21/22 when it was 2,073. Reduction in birth rate is a national trend.

## Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 2022/23 – there were five deaths.

Torbay's perinatal mortality rate for 2022 is 4.2% which is the same as the national average. A deep dive/thematic review was carried out into all deaths in 2022 and no themes or issues with care were identified



### Smoking rates

There has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically the SATOD data was 13-15%. With the introduction of the smoke-free pregnancy team this rate has dropped to 7.3% for the year 2022/23. This is below the national average of 8.6%.

### Identifying fetal growth restriction

Data on our detection of small for gestational age (SGA) babies in quarter four of 2022/23 has evidenced performance above the recommended average. Torbay is one of the top ten trusts in the country for detection of small babies. We have achieved a detection rate of 69.2% which is significantly higher than the national average of 43.6%.

# ANNEX 1: PARTNER STATEMENTS

### Statement from NHS Devon Integrated Care Board [DRAFT 2021 STATEMENT BELOW]

NHS Devon Integrated Care Board (ICB) would like to thank Torbay and South Devon Foundation

### Statement from Healthwatch

[Tbc]

### Statement from OSC

[Tbc]

# ANNEX 2: DIRECTORS' RESPONSIBILITIES STATEMENT

[Tbc following feedback from partners in Annex 1]

NHSE has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- ✓ the content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2022/23 and supporting guidance
- ✓ detailed requirements for quality reports 2022/23
- ✓ the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from the integrated care board for Devon dated 08/08/22
    - feedback from governors following engagement with them at the Council of Governors meeting held on 03 May 2023
    - feedback from Healthwatch, dated 02/06/21
    - feedback from Overview and Scrutiny Committee, dated 11/06/21
    - our complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2022
    - the 2021 national staff survey reviewed by the board in April and May 2023
    - the Head of Internal Audit's annual opinion of our control environment dated 21/06/22
    - CQC inspection reports, dated July 2020 and March 2022
- ✓ the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- ✓ the performance information reported in the quality report is reliable and accurate
- ✓ there are proper internal controls over the collection and reporting of the measures of performance included in the quality report and these controls are subject to review to confirm that they are working effectively in practice
- ✓ the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- ✓ the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board: 28 June 2023

Sir Richard Ibbotson, Chairman

Liz Davenport, Chief Executive

<table>
<tr><td colspan="4">Report to the Trust Board of Directors</td></tr>
<tr><td colspan="3">Report title: Board Assurance Framework and Corporate Risk Register</td><td>Meeting date:<br>28 June 2023</td></tr>
<tr><td>Report appendix</td><td colspan="3">Appendix 1: Board Assurance Framework<br>Appendix 2: Corporate Risk Register</td></tr>
<tr><td>Report sponsor</td><td colspan="3">Director of Corporate Governance and Trust Secretary</td></tr>
<tr><td>Report author</td><td colspan="3">Corporate Governance Manager</td></tr>
<tr><td>Report provenance</td><td colspan="3">Reviewed by Board Sub-Committees – People Committee, Quality Assurance Committee, Finance, Performance and Digital Committee, Building a Brighter Future Committee and Risk Group.</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">Please find enclosed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) for the Board’s review.<br><br>The Board Assurance Framework (BAF) is the key source of evidence that links the Trust’s ‘mission critical’ strategic objectives to risks, controls and assurances, and is the primary tool that the Board uses to discharge its overall responsibility for internal control.<br><br>The Board has delegated detailed review of a number of risks to Board Sub-Committees. During June Board Sub-Committees have reviewed those risks where they have been designated as the overseeing committee. The Risk Group also reviewed the BAF and Corporate Risk Register (‘CRR’) at its most recent meeting.<br><br>The Corporate Risk Register (‘CRR’) is presented alongside the BAF as assurance that the Trust’s risk management system and the risk registers adequately underpin the BAF providing linkage between operational and strategic risks.<br><br>Since the last meeting updates have been made to the Building a Brighter Future and People objectives.<br><br>In addition no new risks have been added to the CRR. The following risk has been removed: 3421 Consultancy vacancy in ITU.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information<br>☐</td><td>To receive and note<br>☒</td><td>To approve<br>☐</td></tr>
<tr><td>Recommendations</td><td colspan="3">The Board is asked to:<br>(i) Review the BAF, and note the updates as described and<br>(ii) Receive and note the Corporate Risk Register.</td></tr>
</table>

| **Summary of key elements** | | | | |
|---|---|---|---|---|
| **Strategic goals supported by this report** | **Excellent population health and wellbeing** | | **Excellent experience receiving and providing care** | |
| | **Excellent value and sustainability** | **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** | **X** | **Terms of Authorisation** | |
| | **NHS England** | **X** | **Legislation** | **X** |
| | **National policy/guidance** | **X** | | |

# BOARD ASSURANCE FRAMEWORK 2022/23

**BOARD ASSURANCE FRAMEWORK SUMMARY**

| Ref | Objective | Executive Lead | Current Risk Score | Target Risk Score | Executive Comment |
|---|---|---|---|---|---|
| 1. | Quality and Patient Experience | CNO | 16 | 12 | |
| 2. | People | CPO | 20 | 16 | Action Log updated |
| 3 | Financial Sustainability | CFO | 25 | 16 | |
| 4 | Estates | CFO | 25 | 10 | |
| 5 | Operations and Performance Standards | COO | 16 | 12 | |
| 6 | Digital and Cyber Resilience | DTP | 25 | 25 | |
| 7 | Building Brighter Future (BBF) | DTP | 15 | 15 | Action Log updated |
| 8 | Transformation and Partnerships | DTP | 16 | 9 | |
| 9 | Integrated Care System | DTP | 16 | 8 | |
| 10 | Green Plan/Environmental, Social and Governance | DCEO | 12 | 6 | |

**Strategic context:**

The Board Assurance Framework ("BAF") is the key source of evidence that links the delivery of the Trust's strategic objectives to risk, control and assurance; and is the primary internal control that the Board uses for strategic oversight and assurance.

The current Trust Strategy was approved in February 2022 and can be found on our website here: https://www.torbayandsouthdevon.nhs.uk/about-us/our-vision-and-strategy/

An Executive Lead is nominated for each BAF Objective, to maintain, review and manage the narrative around each Objective, as well as overseeing the associated risk and controls impacting on delivery. Each Objective is then delegated to a Board Sub-Committee who scrutinise their individual BAF Objectives and undertake a detailed review at each meeting.

The Risk Group also review the BAF and Corporate Risk Register ('CRR').

The Board then undertake a review of the whole BAF, assuring themselves that the narrative and controls contained therein provide sufficient oversight and mitigation of risk as well as noting progress against the Trust strategy; noting the risk position and any exception reporting at their meetings.

**Methodology:**

In reviewing this document Executives will have regard to the Trust's risk management policies, procedures and methodology, as amended from time to time. Noting the importance of tiered mitigation for controls through the "3 lines of defence" as a matter of good governance:

- First Line Assurance - (assessments undertaken and owned by functions that own and manage the risk) – An example of this could be a local monthly compliance check that is undertaken within a specific function.
- Second Line Assurance - (oversight of functions that oversee or who specialise in compliance or the management of risk) – An example of this could be a system, process or piece of assurance that has been reviewed and assessed by the Risk or Governance Team, independently from the first line. Produced distinct from those who are responsible for delivery
- Third Line Assurance - (objective and independent assurance) An example of this could be an assessment of a system and processes by the Trust's Internal Auditors, External Auditors, or regulatory bodies.

The current policies in place are: Risk Management Policy, approved September 2022 & Risk Management Strategy, approved September 2022. It should be noted that these are to be merged during 2023 ensuring consistency of methodology.

When reviewing the BAF objective risk analysis section it should be noted that a risk analysis reference number will be utilised to read across each identified aggravating, mitigation and impact area; linking to gaps in assurance to specific actions. Creating a "golden thread", which is essential for analysis, audit and mapping of risk management.

## BAF Current Risk Score Heatmap

| Likelihood \ Consequence (Impact) | 1 Minimal | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| 5 - Almost Certain | 5 | 10 | 15 | 20 | 2 [6] [4] [3] |
| 4 - Likely | 4 | 8 | [10] 12 | [8] [9] 16 [1] [5] | 20 [2] |
| 3 - Possible | 3 | 6 | 9 | 12 | 15 [7] |
| 2 - Unlikely | 2 | 4 | 6 | 8 | 10 |
| 1 - Rare | 1 | 2 | 3 | 4 | 5 |

| Risk Summary | | | | | |
|---|---|---|---|---|---|
| **BAF Reference:** | **1. QUALITY & PATIENT EXPERIENCE** | | | | |
| **Objective:** | To deliver high quality health and care services ,achieving excellence in health and wellbeing for patients and local community | | | | |
| Internally Driven: ✓ Externally Driven: | | | | | |
| **Responsible Executive:** | Chief Nurse supported by CMO | **Committee:** | Quality Assurance Committee | **Last Updated:** | May 2023 |

**BAF Risk Scoring**

| Current Position | | | | | Target Position | Year on Year | Rationale for Risk Level |
|---|---|---|---|---|---|---|---|
| | **Jul 22** | **Nov 22** | **Jan 23** | **Mar 23** | **April 24** | **May 22** | There are a range of factors that present a risk to delivering high quality health and care .These include the ongoing and accumulate impact of the following: |
| **Likelihood** | 5 | 4 | 4 | 4 | 4 | n/a | |
| **Consequence** | 4 | 4 | 4 | 4 | *3* | n/a | |
| **Risk Score** | 20 | 16 | 16 | 16 | 12 | n/a | • Demand and Capacity modelling presents a significant gap in terms of TSDFT meeting levels of activity at pace and scale<br>• Unstable operating model and newly emerging structure<br>• Ambiguity around accountability and leadership capacity issues across the Care Group Delays in accessing treatment and care due to waiting list position and harm experienced as a result of significant delays<br>• Continued Pressure on the emergency pathway and patient flow resulting in delays in management of patients in the right place at the right time<br>• Newly emerging clinical governance from April 1st<br>• SOF 4 accelerate pace and scale of service, pathways change which may adversely impact a range of issues around workforce as we progress efficiency, performance and productivity drive<br>• Workforce Challenges in terms of attrition, sickness and moral – to be further impacted by Industrial action over quarters 3 and 4 of 2022/23<br>• There remains a Moderate risk to the quality of patient care. The likelihood of the risk materialising remains as Likely (x). |

**Risk Scoring Analysis**

| Aggravating Factors increasing risk profile: | | Mitigating Factors (internal controls): | | Impact of risk occurring: | |
|---|---|---|---|---|---|
| 1.1A | Pace and scale of change required to minimise harm and poor patient experience & meet SOF 4 exit criteria is a significant challenge. | 1.1B | Setting out medium to long term plan for reconfiguration of services to meet risk/demand<br><br>Recovery and Restoration plan with agreed targets as set out in Performance framework and operating plan for planned and emergency Care | 1.1C | Inequities and inequalities in access resulting in increase in Mortality& Morbidity across Torbay and South Devon |
| | | | | | Performance and operational resilience remained constrained with ongoing impact of :<br>a) Delays in diagnostics and access to treatment - analysis of harm in key high-risk service areas shows an increase in harm in Ophthalmology, Urology, Cancer Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | Regular review Mortality and Morbidity through to Board incorporated into overall Harm review framework and through QA Governance framework | | b) Failure to achieve recovery and restoration targets set out in the Recovery Plan<br>c) Delayed ambulance handovers<br>d) Adverse Mortality and Morbidity |
| 1.2A | Clinical Leadership Capacity to lead change | 1.2B | Acute Service Sustainability Plan in development | 1.2C | Failure to deliver fundamental standards of care as set out in regulatory/statuary frameworks |
| 1.3A | Gaps in Leadership Capacity and Capability across new Care Group Structure | 1.3B | TSDFT Leadership Strategy<br>Active recruitment to key leadership roles | 1.3C | Failure to deliver against Single Improvement Plan targets – Regain and Renew |
| 1.4A | Gaps in expertise and Capacity within the Quality and Patient safety functions across TSDFT | 1.4B | Recruitment to Associate Director pf Patient Safety<br>Business Case for Patient Experience lead | 1.4C | Delays in delivery against national and regulatory frameworks of Patient safety and Patient Experience |
| 1.5A | Capacity and capability to monitor /interrogate business/clinical Intelligence data including workforce, operational performance, quality and safety immature and sub optimal | 1.5B | Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and SOF 4 criteria | 1.4C | Failure to intervene and prevent patient Harm issues and underperformance around SOF 4 |
| 1.6A | Maturing quality /governance systems across organisation and within the newly emerging Care Group structure - impacting effectiveness of quality systems – assurance /improvement | 1.6B | Broader Corporate Governance Review including strengthened Clinical Governance Framework in line with GGI recommendations | 1.6C | Sub-Optimal Quality Assurance framework - Failure to address quality and patient safety risk and to effectively drive up quality improvement<br>a) Continuous review of NICE recommendations and communication of new/changing requirements by the Quality Effectiveness Team.<br>b) Monitoring framework of concerns and feedback from patients and service users<br>c) Embedding key programs of work to ensure fostering of Safety Culture work |

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk Analysis reference:** | | **Risk Analysis Reference:** | |
| 1.3A | Operating structure in transition | 1.1C | System /ICS around plans to address inequalities in access and treatment |
| 1.3A | Need to implement and embed new operating structure and CG framework in line with staff engagement and GGI report - Launch 1st July | 1.1C | Central government control restricting ability to prioritise local needs |
| 1.3A | Need to strengthen role of Trust Management Group Absence of Executive performance Oversight and monitoring outside Board Sub-Committee | 1.1C | Collaboration with Devon system to ensure joined up response to increasing pressures |
| 1.6A | Quality of clinical data variable | 1.6A | CQC new regulatory approach not yet tested. |
| 1.3A | Need comprehensive Organisational development plan to support system wide leadership capacity | 1.1C | System /ICS around plans to address inequalities in access and treatment |

| Action Log: (actions identified to achieve target risk score) | | | | |
|---|---|---|---|---|
| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
| 1.2B | Continue acute service collaborative and delivery of the Acute Service Sustainability Plan | CEO | Ongoing 2023 | • ICB plan in place - Single Operating Plan for 2023/24<br>• System approach to service reviews through PASP<br>• Governance and oversight in place<br>• SRO in place – TSDFT CEO |
| 1.1A | Ensure delivery against SOF 4 Exit Criteria in terms of quality and improved performance | COO | April 2024 (to review) | • Improvement Targets agree- set out in SOF 4<br>• Detailed plans developed with support of recovery<br>• Recovery and Improvement Board established |
| 1.5A | Ensure robust oversight arrangements in place around understanding and monitoring intelligence around harm | CMO | Ongoing monthly group | • Harm Review Group in line with ICB oversight around Clinical Risk and Long Waits assurance Group<br>• Mortality review /process in place to understand recent increase in Mortality – linking with ICS<br>• Review of clinical outcomes for patients delayed in ED |
| 1.6A | Ensure robust measures are in place to compliance with Fundamentals of care and ongoing delivery against the CQC improvement requirements from March 2020 and March 2022 Improvement Plans | CNO | July 2023 | • Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and SOFT 4 criteria<br>• Ward Accreditation Framework in place and strengthened in 2022/23<br>• Internal audit around compliance against 2020 CQC Action Plan completed in Autumn 2021<br>• Ongoing Quality and safety walkabout in place Current underperformance around Training a risk - revised assurance submitted to People Committee in June 22<br>• Consistent Monitoring of the Nutrition and Hydration and risk assessment show good levels of compliance with some areas requiring closer scrutiny – areas known to leadership<br>• Mandatory Training Improvement plan continues to be monitored - ongoing monitoring through Care Group Structure and People Committee to ensure trajectory is met. |
| 1.6A | Develop and implement improvements to the Clinical Governance Framework as set out in GGI | CNO | April 2023 | • Revised Structure to go live in July 2023<br>• Review submitted to QAC March 2023 with launch/go live governance structure from 1st April<br>• Co- Designed Care Group Governance in line with GGI and NHSE Accountability Framework Risks remain around capacity/ capability at corporate and ISU level<br>• AWS to deliver development program |
| 1.3A | Strengthening of quality oversight and assurance at service at Care group level through new operating model | CNO | July2023 | • New operating model in place- Launch 1st April<br>• ISU's recording and monitoring all quality meetings where metrics are reviewed and action plans created. |
| 1.6A | Review of current quality metrics reported in the KLOE Dashboard to ensure they are relevant. | CNO | Ongoing 2023 | • Phased work program in place led by DoF<br>• KPIS Reviewed for QI Priorities<br>• New Quality Metric introduced in IPR |

| | | | | |
|---|---|---|---|---|
| | | | | • Date being developed with overarching audit framework and digital platform Formic |
| 1.4A | Development of the Patient Experience and Engagement Strategy to strengthen our understanding of patient experience and involvement of patients.<br>Set out specific interventions to enhance experience of patients for 23/2024 | CNO | April 2023 | • Patient Engagement Strategy launched August 2022<br>• Plan to be further developed in 2023/24 to be clear about measurable deliverables around priorities |

| Risk Summary | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **BAF Reference:** | | **2. PEOPLE** | | | | | | | | |
| **Objective:** | | To build a culture where our people feel safe, healthy and supported. | | | | | | | | |
| Internally Driven: ✓ Externally Driven: | | | | | | | | | | |
| **Responsible Executive:** | | Chief People Officer | **Committee:** | People Committee | | | | **Last Updated:** | June 2023 | |

| BAF Risk Scoring | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Current Position** | | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
| | **Jul 22** | **Nov 22** | **Jan 23** | **Mar 23** | **Apr 23** | | **May 22** | SOF4 has highlighted the improvements required in reducing waiting list times and improving financial efficiency. Whilst improvements in processes can alleviate both, people remain the key deliverers of all services, often doing so against competing demands and priorities. Workforce fragility data (sickness, rolling sickness, long term sickness, age profile, holiday taken, overtime hours, bank and agency spend, and turnover) highlights that 6 out of 9 are in red RAYG status. The difficulty in analysing the impact of this is compounded by poor vacancy data quality. All of these categories place growing pressure on workforce to continue to deliver but with less available resource. In addition, organisational culture data from People survey, DES, WRES, EDS, F2SU, and demands on the Employee Relations team, identifies that the Trust has room to build a culture where people feel safe, healthy and supported. The link between this culture and patient safety is actively being investigated, with the full degree of risk to patient safety yet to be understood. |
| **Likelihood** | 4 | 4 | 4 | 4 | 5 | 4 | n/a | |
| **Consequence** | 4 | 4 | 4 | 4 | 4 | 4 | n/a | |
| **Risk Score** | 16 | 16 | 16 | 16 | 20 | 16 | n/a | |

| Risk Scoring Analysis | | | | | |
|---|---|---|---|---|---|
| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
| 2.1A | Turnover, and difficulties recruiting to critical posts, means there is an increase in services with 15+ risks with staffing factors. | 2.1B | Use of interims and agency staff to cover the gaps, as well as exploration of peninsular solutions to addressing fragile services. | 2.1C | Loss of ability to deliver some key services; increased agency and interim spend |
| 2.2A | Staff fatigue following covid pandemic, annual leave not being taken due to operational pressure and covering additional shifts is leading to staff burnout. The requirement to improve performance to reduce long waiting lists will likely add mental load to individuals. | 2.2B | Suite of wellbeing offers available via Devon Wellbeing, EAP and OH. | 2.2C | Increased level of sickness, long term sickness above normal levels, staff turnover, impact on uptake of annual leave, and a decrease in productivity and performance in staff that remain. |
| 2.3A | Lack of strategic business and workforce planning, to identify the workforce needed for the future, with sufficient time for us to develop the appropriate pipeline to deliver the need. Also, a lack of a clear view on how the ICS will work together. | 2.3B | Strategic Workforce Planner has been recruited, to start Jul 23. | 2.3C | It takes time to recruit and grow patient facing skills and staff – there will be a lag between strategic workforce plan being created and people starting, therefore vacancies will continue to exist in specialist areas |
| 2.4A | Lack of leadership or management framework, development or key accountability expectations, results in workforce expressing dissatisfaction and impact on wellbeing due to poor leadership and management | 2.4B | A co-created leadership framework, (Include, Listen, Act) and a management training programme have been designed. Now approved at Board , the roll out plan to commence Q2 23. Leadership framework will used to identify leadership expectations, standards & behaviours. Evaluate (through a 360 | 2.4C | Continued poor leadership and management behaviours will exasperate an already fragile workforce and reinforce that their concerns are not listened to, further compounding fragility challenges. |

| | | | | | |
|---|---|---|---|---|---|
| | | | approach), recruit and develop leaders to improve effectiveness and consistency in leadership. | | |
| 2.5A | Capacity to deliver services impacted by industrial action | 2.5B | Concise industrial action planning involving patient facing and operational teams, supported by reward and recognition where necessary, has enabled most services to continue | 2.5C | Further detriment to staff resilience and wellbeing, for those who have cause to strike, and those required to cover services.<br>Staff prevented from participating in CPD due to operational pressures which impact on career pathway work and retention. |
| 2.6A | Operational pressures result in increased time in OPEL 4, that impacts on wellbeing of staff and ability to attend CPD. | 2.6B | Clear process and policy to review CPD attendance at times of OPEL 4 | 2.6C | Staff prevented from participating in CPD due to operational pressures which impact on career pathway work and retention. |
| 2.7A | Unclear career pathways and talent management impacts on retention and wellbeing of workforce | 2.7B | People Promise work will design clear career pathways and a trust wide talent management plan. Work to commence Q2 23 | 2.7C | Impact on recruitment and retention of workforce against an already difficult vacancy picture. |
| 2.8A | Absence and turnover, as well as inconsistent use of rotas, increases use of bank and agency staff | 2.8B | Improved recruitment processes, e-rostering roll out, temporary staffing management and an improved triangulation of data with finance and payroll has reduced agency spend for nursing and midwifery. | 2.8C | Increased use of bank and agency creates cost pressures, especially when used to cover absence. The cost pressures contributed to declining Trust financial performance. |
| 2.9A | In drive to recover from SOF4 there are an abundance of initiatives underway to improve waiting lists, patient safety, cost improvement and innovation, as well as introducing new leadership and management frameworks, and preparing for a CQC Well Led Inspection | 2.9B | Execs are trialling a prioritisation tool to clarify which of competing tasks are actual priority and to understand the dependencies on resources to deliver the priorities. Intent is to provide clarity to workforce to alleviate some pressure. Regain and Renew engagement plans is also asking workforce to focus on what can deliver that offers most impact to recovery. | 2.9C | Continued culture of trying to do everything will exasperate workforce fatigue and wellbeing decline, and not aid recovery. |
| 2.10A | An upward trend in EDI related investigations and Employment Tribunals, combined with an in increased reported number of bullying and harassment instances on BAME staff, and an overall decline in experience for our people with LTC (Staff Survey Results 2022), suggests that the workplace culture in TSD is not inclusive. | 2.10B | Just and Learning Culture survey, aligned to Patient Safety, currently in circulation to help identify where in Trust there are particular issues in psychological safety. New Leadership framework has inclusivity at its heart. OD team to be renamed as Inclusivity and Culture team to focus on a) culture, inclusion and wellbeing education, rewrites of policies to reflect Just and Learning Culture, and to triangulate data from multiple sources to identify where bespoke interventions may be required. | 2.10C | By not treating this risk the Trust will be unable to achieve its objective to build a culture where our people feel safe, healthy and supported. Incidents of incivility impact on staff retention |
| 2.11A | Lack of accurate vacancy data and correlation with financial data | 2.11B | Organisational Reshaping project is providing opportunity for all cost centres and ESR to be rebuilt to accurately reflect establishment and new design. Should result in clearer vacancy data | 2.11C | Lack of clear vacancy data impacts on a) clear resourcing priorities and workforce planning, b) lack of risk management for shortage of skills, c) unclear financial data regarding cost of certain skills groups |
| **Gaps in control/assurance** | | | | | |

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 2.1A | Thorough oversight of vacancies and use of agency and interims is required across the Trust | | |
| 2.2A | Wellbeing tools only treat symptoms, need to get to cause of symptoms and treat these. Increased perceived workloads to be managed via Regain and Renew call to only focus on key recovery areas; but org culture requires improvement. | | |
| 2.10A | 1. EDI training is not part of induction<br>2. Skillset of managers to enforce policy or to investigate is in need of improvement<br>3. Capacity of People Hub team is stretched against backdrop of current caseload, captured in Risk 3536 | | |

**Action Log: (actions identified to achieve target risk score)**

| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
|---|---|---|---|---|
| 2.1A | New oversight and management of agency and interim spend to be introduced with aim to reduce spend and to meet workforce plans aims of CIP and reduced agency spend | CPO | Mar 24 | Agency use monitored through Nursing & Midwifery Workforce Transformation Council from June 2023 and reported into Recovery group. |
| 2.2A | To improve the organisational culture, and therefore the well being of the workforce, a plan is required to Create abnd Embed and Inclusive Culture in TSD | CPO | Sep 23 | Cultural improvement plan to be presented at People Committee 26.06.23 |
| 2.10A | 1&2 New TSD Leadership and Management framework and resources will be launched from Summer 2023 that focus on a leadership responsibility of all to include. Will involve refreshed EDI training, | CPO | Sep 23 | Leadership framework approved by Trust Board. All products – based on the framework- including a 360 and leadership & management induction programme under development. |
| **2.10A** | 3. People Hub capacity under review, uplift of resource and interim support to identify and manage backlog, introduction of prioritisation of projects and dependency management at Exec level should manage demand on People Hub | CPO | **Dec 23** | Interim People Hub manager in post until Dec 23 and uplift to resources now in place June 23. |

## Risk Summary

| | |
|---|---|
| **BAF Reference:** | **3. FINANCIAL SUSTAINABILITY** |
| **Objective:** | To achieve financial sustainability and deliver the ICS three year financial recovery plan, enabling appropriate investment in the delivery of outstanding care. |

Internally Driven: ✓ Externally Driven:

| **Responsible Executive:** | Chief Financial Officer | **Committee:** | Finance, Performance and Digital Committee | **Last Updated:** | May 2023 |
|---|---|---|---|---|---|

## BAF Risk Scoring

| **Current Position** | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
|---|---|---|---|---|---|---|
| | **Jul 22** | **Nov 22** | **Mar 23** | **April 24** | **May 22** | There is a risk that the Trust fails to deliver sufficient improvement in its and productivity to achieve the three year system recovery plan. This will result in regulatory intervention, further financial restriction, leading to issues with access to services, including waiting times, increased health inequalities, and an inability to improve and update equipment and infrastructure for the benefit of patients and staff. Some services may not be viable in the medium term. |
| **Likelihood** | 5 | 5 | 5 | 4 | n/a | |
| **Consequence** | 5 | 5 | 5 | 4 | n/a | |
| **Risk Score** | 25 | 25 | 25 | 16 | n/a | |

## Risk Scoring Analysis

| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
|---|---|---|---|---|---|
| 3.1A | Inflation outstrips funding available resulting in a deterioration in financial performance | 3.1B | Contract negotiation and non-pay controls | 3.1C | Deterioration in financial performance and failure to deliver SOF 4 exit requirements |
| 3.2A | Digital and physical environments are not fit for purpose | 3.2B | Multi-year capital programme and bids for additional cash-backed external funding | 3.2B | Failure to improve productivity therefore not delivering financial nor operational improvements to exit SOF 4 |
| 3.3A | Recruitment and retention are difficult for highly skilled clinical staff | 3.3B | See workforce risk – people promise, workforce planning, R&R initiatives | 3.3B | Unsustainable rotas, fragile services, and failure to delivery SOF 4 exit requirements |
| 3.4A | Failure to comply with best practice guidance such as GIRFT and model hospital | 3.4B | Transformation programme and PMO team supporting improvement workstreams | 3.4B | Failure to deliver best value (quality / cost) impacting negatively on SOF 4 exit |
| 3.5A | Material differences between income and costs for specific services most notably adult social care | 3.5B | Multi-agency recovery and transformation programme supported by external experts | 3.5B | Unsustainable provider market and increasing gap between income and cost, resulting in financial deterioration and impacting on SOF 4 exit |
| 3.6A | Capacity and capability of senior budget holders is variable | 3.6B | Communication, engagement and training packages, plus business partnering approach | 3.6B | Failure to demonstrate sufficient accountability for delivery to assure SOF 4 exit |
| 3.7A | Gaps within the CIP programme | 3.7B | Transformation and PMO approach including system-wide saving schemes with appropriate external support | 3.7B | Deterioration in financial performance and failure to deliver SOF 4 exit requirements |

| Gaps in control/assurance | | | |
|---|---|---|---|
| **Internal** | | **External** | |
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 3.3A | Ongoing challenges with data quality and information availability, driven by limited capability of digital systems and significant capacity issues in data warehousing | 3.5A | Slow release of agreed funding through ICB impairs organisational implementation of agreed actions and delays improvements to speed of response to patient need. |
| 3.3A | GIRFT response, has been inconsistent, missing an opportunity to implement best practice | | |
| 3.5A | Impact of operational pressures on ability to deliver financial plans. | | |
| 3.5A | Reintroduction of activity-based payments on the horizon with limited in-house capacity to support | | |
| 3.6A | Productivity has not recovered to pre-Covid levels and recovery funding is often non-recurrent in nature | | |

| Action Log: (actions identified to achieve target risk score) | | | | |
|---|---|---|---|---|
| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
| 3.7A | Establish Recovery Group to oversee key strands of SOF 4 exit | CFO | March 23 | Complete |
| 3.5A/3.7A | Efficiency plan for 2023/24 | CFO | June 23 | In delivery, significant gap with developing mitigations. |
| 3.2A | Systems improvements (Prevero, Tableau, Genesis) | DOpFin | Sept 23 | Underway with risk of slippage |
| 3.2A | Ensure full reconciliation of workforce and financial data | DOpFin | Sept 23 | Still work in progress – now depends on additional input within Workforce Information Team |
| 3.5A/3.7A | Financial comms campaign | Del Dir | Dec 22 | Complete |
| 3.2A/3.5A/ 3.7A | Develop MTFP in line with revised ICS principles and methodology (then informing BBF business cases) | DOpFin | Sep 23 | First stage (baseline) complete – now aligned with key business cases. Next steps to overlay strategic interventions, BBF, digital, acute service strategy – external support (ICS level) in place |
| 3.6A | Embed new accountability framework alongside new ops structure | CFO | Sep 22 | Delayed – new ops structure to be embedded. Proforma accountability agreements developing through COO |
| 3.4A | SFI refresh taking account of (8) | DOpFin | Jul 23 | |

## Risk Summary

| | | | | | |
|---|---|---|---|---|---|
| **BAF Reference:** | **4. ESTATE** | | | | |
| **Objective:** | Provide a fit-for-purpose estate that supports the delivery of safe, quality care. | | | | |
| Internally Driven: ✓ Externally Driven: | | | | | |
| **Responsible Executive:** | Chief Finance Officer | **Committee:** | Finance, Performance and Digital Committee | **Last Updated:** | May 2023 |

## BAF Risk Scoring

| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
|---|---|---|---|---|---|---|---|
| | **Jul 22** | **Nov 22** | **Jan 23** | **May 23** | **2030** | **May 22** | Currently, the estate consists of around £60m worth of backlog maintenance (£120m with on-costs included) and the lack of adequate long-term capital funding to ensure this backlog is adequately addressed, is causing a failure to provide a fit-for-purpose estate that supports the delivery of safe, quality care. There are multiple impacts of this, including: unplanned cancellation of clinical services due to failure of aged plant and fabric; potential impact on ability to meet RTT and other contractual clinical standards; increased risk of harm to staff, patients or members of the public; increased estate maintenance revenue costs; and a risk of financial penalties due to clinical breaches and potential claims. |
| **Likelihood** | 5 | 5 | 5 | 5 | 2 | n/a | |
| **Consequence** | 5 | 5 | 5 | 5 | *5* | n/a | |
| **Risk Score** | 25 | 25 | 25 | 25 | 10 | n/a | |

## Risk Scoring Analysis

| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
|---|---|---|---|---|---|
| 4.1 A | The estate is heavily dilapidated with £60m of backlog reported to NHSEI through the Estates Return Information Collection (ERIC) in 2022 (half is high and significant risk) | 4.1B | Authorisation of NHP infrastructure monies | 4.1C | Increased demand on Workplace Team resources to maintain and improve the overall estate |
| 4.2 A | Engineering infrastructure capacity, capability and resilience to maintain activity and safe environments | 4.2 B | Oversight and scrutiny of estates statutory compliance systems by the Workplace Performance & Compliance Group (WPCG) regularly reporting to FPDC and Trust Board (and Risk Group where appropriate) ensuring this supports the Trust's SOF4 exit strategy | 4.2 C | Increased demand on capital funding to deal with fundamental capacity and resilience issues, resulting in other issues identified within backlog not being deferred and operated on a run-to-fail basis |
| 4.3 A | Appropriate, proportionate and timely level of funding | 4.3 B | Capital investment administered by the Capital Investment & Delivery Group (CIDG) | 4.3 C | Increased demand on capital funding to deal with fundamental capacity and resilience issues, resulting in other issues identified within backlog not being deferred and operated on a run-to-fail basis |
| 4.4 A | Delivery of partnership developments (e.g. Health and Wellbeing Centres) with multiple agencies | 4.4 B | Devon Plan | 4.4 C | Not being able to support effective efficient services may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives. |
| 4.5 A | Inability to improve and reconfigure the estate due to significantly aged infrastructure and insufficient funding impacting the delivery of clinical activity (e.g. lack of suitable clinical rooms to meet demand, insufficient office-accommodation to meet needs of all clinical and non-clinical teams) | 4.5 B | Enhanced joint working between the Workplace Team and Clinical Teams to reduce the impact of any issues arising from premises incidents, again ensuring that Workplace Team outputs meet clinical needs to enhance patient experience and ensure SOF4 exit criteria is met where Workplace are an enabler | 4.5 C | Not being able to support effective efficient services and meet the basic needs of Trust staff (e.g. through the provision of fit-for-purpose office accommodation) may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives |

| | | | | | |
|---|---|---|---|---|---|
| | | | Closer collaboration with both Infection Prevention and Control and Health and Safety Colleagues to ensure significant safety risks associated with the inability to improve or reconfigure the estate are mitigated where reasonably practicable | | Constrained ability to improve environment at pace to meet clinical, staff and SOF4 exit needs<br><br>Damage to the Trust's reputation both as a provider of care and an employer<br><br>Potential for litigation due to claims from employees on the basis that basic, fit for purpose working accommodation is not being provided<br><br>Constrained ability to effect strategic change and improvements to buildings and environments. |
| 4.6 A | Aging premises, requiring additional servicing and repair | 4.6 B | Pre-planned maintenance schedule across a 12-month period to ensure areas at higher risk of failure are proactively inspected, maintained and repaired.<br><br>Regular oversight and signposting from local Workplace Teams to resolve premises and operational issues | 4.6 C | Excess demand on capital programme and project management resource inhibiting the team's ability to deliver both capital programme and strategic projects effectively<br><br>Increased demand on Workplace Team resources to maintain and improve the overall estate |
| 4.7 A | Premises infrastructure and layout not efficient for modern healthcare needs. | 4.7 B | Enhanced joint working between the Workplace Team and Clinical Teams to reduce the impact of any issues arising from premises incidents, again ensuring that Workplace Team outputs meet clinical needs to enhance patient experience and ensure SOF4 exit criteria is met where Workplace are an enabler | 4.7 C | Not being able to support effective efficient services and meet the basic needs of Trust staff (e.g. through the provision of fit-for-purpose office accommodation) may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives<br><br>Constrained ability to effect strategic change and improvements to buildings and environments. |

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| **4.6 A** | Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity | **4.1 C** | Insufficient capital funds available to address all high priority risks over a 5-year period |
| **4.6 A** | Equipment and plant continue to fail and due to age, cannot always be repaired | **4.3 C** | Insufficient funds available to address all high priority risks over a 5-year period |
| **4.2 A** | Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities. | | |

| Action Log: (actions identified to achieve target risk score) | | | | |
|---|---|---|---|---|
| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
| 4.1A | Revised Estates Strategy and investment plan to manage aging infrastructure that connects current risk through to the completion of Building a Brighter Future | CFO | 01/09/2023 | When the revised strategic outline business case (SOC) for NHP is approved the outline business case (OBC) level Estates Strategy will be developed. |
| 4.2 A | WPCG, Workplace Risk Group & CIDG continued prioritising of focus, mitigation and investment in high and significant risk areas | CFO | Ongoing | Ongoing governance in this space. New risk-based approach taken to 5-yearly capital planning process, using a combination of backlog information and known risks to prioritise investment. |
| 4.3 A | Submit bids for capital funding at every opportunity for either Critical Infrastructure Risk funding or clinical specific initiatives that also indirectly reduce backlog and improve the estate and patient environment | CFO | Ongoing | • Endoscopy 4th room (funding approved July 2022)<br>• TIF bid for day surgery theatres (target completion late 2023)<br>• New RT/CT scanners – in progress<br>• 5-year capital plan now agreed – focussed on six-facet survey and BBF as foundation |
| | Continued development of the approach to Pre-Planned Maintenance to ensure continuous compliance with statutory regulations and enhanced focus on known areas of failure | CFO | 05/06/2023 | Complete – PPM schedule developed for next twelve months, covers statutory requirements and enhanced maintenance in areas of known risk/increased likelihood of asset failure – 100% completion rate for all pre-planned maintenance activity in January, February, March and April. |

**Risk Summary**

| | |
|---|---|
| **BAF Reference:** | **5. OPERATIONS AND PERFORMANCE STANDARDS** |
| **Objective:** | To deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care |
| Internally Driven: ✓ | Externally Driven: |

| **Responsible Executive:** | Chief Operating Officer | **Committee:** | Finance Performance and Digital Committee | **Last Updated:** | May 2023 |
|---|---|---|---|---|---|

**BAF Risk Scoring**

| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
|---|---|---|---|---|---|---|---|
| | **Jul 22** | **Nov 22** | **Jan 23** | **Mar 23** | **April 24** | **May 22** | Consequence: Performance Risk - Failure to meet professional standards or statutory requirements.<br><br>Likelihood: If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences. |
| **Likelihood** | 4 | 5 | 5 | 4 | 3 | n/a | |
| **Consequence** | 5 | 4 | 4 | 4 | 4 | n/a | |
| **Risk Score** | 20 | 20 | 20 | 16 | 12 | n/a | |

**Risk Scoring Analysis**

| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
|---|---|---|---|---|---|
| 5.1.A | Imbalance between time of emergency admissions and discharges | 5.1.B | Daily Control meetings to align daily discharges with daily admissions.<br>Work programme of transformation improvement team in respect of urgent care recovery plan.<br>UEC Board improvement programmes overseen by Trust Recovery Board | 5.1.C | Delays in progressing patient decisions resulting in delays in treating patients both internally and externally (ambulance availability) |
| 5.2.A | Insufficient capacity in Care Home and Domiciliary care market | 5.2.B | Work programme of transformation improvement team in respect of urgent care recovery plan.<br>UEC Board improvement programmes overseen by Trust Recovery Board<br>Agreement on funding arrangement to incentivise market development. | 5.2.C | Increased number of patients with no criteria to reside and reduced bed capacity for emergency and elective patients leading to an inability to treat patients in a timely way resulting in harm. |
| 5.3.A | Continued infection outbreaks resulting in reduced bed capacity and ability to move patients to the right bed | 5.3.B | Daily Control meetings include IPC representatives who work with operational staff to maximise bed capacity while ensuring safe care.<br>Reviews of IPC controls to ensure alignment with national guidance. | 5.3.C | Misalignment of bedded capacity resulting in increased LOS and bed occupancy resulting in delays to treatment and harm |
| 5.4.A | Insufficient internal and externally sourced capacity to manage elective demand | 5.4.B | Work programme of transformation improvement team in respect of planned care recovery plan.<br>Planned Care Board improvement programmes overseen by Trust Recovery Board.<br>Weekly PLT review meetings to progress patient pathway for Cancers and Electives.<br>Tier 1 Regional Support .<br>Regional Mutual Aid including access to Nightingale Hospital Exeter. | 5.4.C | Failure to deliver on SOF4 exit criteria resulting in reduced organisational control |

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|---|---|---|---|---|---|
| 5.5.A | Inadequate information and data analysis to respond to emerging threats. | 5.5.B | Information and Performance are members of the Planned Care Board and UEC Board improvement programmes overseen by Trust Recovery Board and engage with requests to deliver required information. | 5.5.C | Misalignment of capacity resulting in delays to treatment and harm |
| 5.6.A | Low skill level of staff in managing non-elective and elective demand | 5.6.B | Weekly Manager's Grand Round training programme.<br>Restructure of operational and accountability framework | 5.6.C | Impaired management capacity to progress improvement and daily operational work resulting in disengagement from clinical staff and poor implementation of agreed actions. |

**Gaps in control/assurance**

| Internal | | External | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 5.1.A | Appropriately assessed and agreed job plans are required to ensure resources are directed most effectively at the key areas for operational delivery | 5.2.A | An unstemmed decline in available workforce to ensure sufficient capacity for patients no longer needing acute care reduces bed capacity for emergency and elective patient demand. |
| 5.5.A | Inadequate information systems result in poor decision making and difficulties in accurately determining drivers for performance. | 5.4.A | Slow release of agreed funding through ICB impairs organisational implementation of agreed actions and delays improvements to speed of response to patient need. |
| 5.6.A | Insufficiently skilled management resource impairs swift analysis of and response to operational issues. | | |

**Action Log: (actions identified to achieve target risk score)**

| Risk analysis reference: | Action required: | Executive Lead: | Due Date: | Progress Report: |
|---|---|---|---|---|
| 5.1.A | Deliver agreed policies and procedures to facilitate adherence to early discharging and weekend discharging | COO | Jun 23 | Earlier weekday discharges occurring but not complete. Weekend Discharges action review and development in place. |
| 5.1.A | Clarification of use of emergency care capacity to facilitate increased ambulatory SDEC | COO | May 23 | Space identified. Clinical Discussions planned. |
| 5.2.A | Refining allocation of funding to support development of care home and domically care markets | COO | Mar 23 | Complete |
| 5.2.A | Ensure effective partnership working at regional and local level | COO | Mar 23 | Complete |
| 5.3.A | Changes to IPC arrangements to be in line with national guidelines | COO | Mar 23 | Complete |
| 5.4.A | Establishment of TSD UEC Board and Planned Care Board to focus actions on delivery | COO | May 23 | UEC Board TOR agreed. Planned Care Board in development. |
| 5.4.A | Establishment of outsourcing and Insourcing capacity to manage demand | COO | Apr 23 | Funding clarified, contracts in train, additional capacity discussions underway |
| 5.5.A | Development of new EPR and data system | DT&P | Jan 25 | Funding streams in development |
| 5.6.A | Operational Restructure | COO | Jun 23 | Structure completed, plans for implementation in development. |

| **Risk Summary** | | | | | | | | |
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| **BAF Reference:** | **6. DIGITAL AND CYBER RESILIENCE** | | | | | | | |
| **Objective:** | To provide clinical and administrative IT systems, and supporting digital infrastructure, that efficiently and cost-effectively meet the Trust's clinical models of care and key business needs, and support the confidentiality, integrity and availability requirements of a modern health and care provider delivering 24 * 7 * 365 services. | | | | | | | |
| Internally Driven: ✓ | Externally Driven: | | | | | | | |
| **Responsible Executive:** | Director of Transformations and Partnerships | | **Committee:** | | Finance, Digital and Performance Committee | | **Last Updated:** | May 2023 |

| **BAF Risk Scoring** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
| | **Jul 22** | **Nov 22** | **Jan 23** | **May 23** | **April 24** | **May 22** | Current IT systems and supporting infrastructure will not meet the current of future business need. |
| **Likelihood** | 5 | 5 | 5 | 5 | 5 | n/a | The current likelihood has increased for two reasons, firstly the level of known vulnerability of the PAS / LIMS systems which will cease to be supported from 2024. National security vulnerabilities (such as Log4shell) are significant concerns to IT systems globally, additionally the situation in Ukraine has increased the likelihood of nation-state level cyber-attacks. |
| **Consequence** | 5 | 5 | 5 | 5 | 5 | n/a | |
| **Risk Score** | 25 | 25 | 25 | 25 | 25 | n/a | The current consequence is scored at 5 as the reliance on digital systems in the delivery of business processes and clinical services is high and the impact of a cyber-attack could be catastrophic (for example, extended loss of essential service in more than one critical area) |

| **Risk Scoring Analysis** | | | | | |
|---|---|---|---|---|---|
| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
| 6.1A | Failure to meet cyber security or information governance standards<br>Cyber-attack – local or global e.g. malware / ransomware / zero-day threats | 6.1B | Data Security and Protection Toolkit in place with Standards Met which include compliance to Cyber Essentials<br>Process in place to review and respond to national NHS Digital CareCERT notifications<br>Anti-virus, anti-malware software in place. All devices end user (laptops and desktops) and servers are enrolled in Microsoft ATP (advanced threat protection software)<br>2022/23 capital plan, including external Frontline Digitisation funding<br>An 'onion layer' of countermeasures and an ongoing investment in refreshing and adding to these to address an ever-evolving threat | 6.1C | A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts<br>Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences<br>Damage to the Trust's reputation e.g. Loss of local services, IG Breach, Financial loss |
| 6.2A | Computer hardware risks<br>Key infrastructure components failing due to age/lack of support | 6.2B | IT Infrastructure Action Plan in place, supported by 2022/23 £8.5m capital funding from Frontline Digitisation<br>IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical areas | 6.2C | A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current |

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| | | | | | inpatients and planned care to neighbouring trusts<br>Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences<br>Damage to the Trust's reputation e.g. Loss of local services, IG Breach, Financial loss |
| 6.3A | Failure to secure funding to implement an EPR<br>EPR solution not being sufficiently flexible to deliver level of clinical transformation required | 6.3B | EPR business case at OBC stage, with a clear route to national funding<br>Trust has an approved Digital strategy that aligns with the delivery of the Trust Strategy and the ICS digital strategy<br>Regain & Renew/SOF4 Exit transformation priorities being aligned with change/transformation driven by the EPR implementation<br>Clinical pathways being aligned across organisations, enabling standardisation in a shared EPR<br>The Trust Board has undertaken the NHS Providers Digital Boards Programme and has a NED with a specialist expertise in Digital | 6.3C | Inability to maintain 'many systems' approach for both technical (complexity) and financial reasons, leading to limited support for business needs<br>Inability to participate in System-level clinical pathways, reducing or eliminating the opportunities to support fragile/inefficient clinical services, and risking fundamental Trust operations |
| 6.4A | End of software product life (e.g. PAS, LIMS) | 6.4B | 2022/23 capital plan, including external Frontline Digitisation funding<br>Critical systems identified with clinical and corporate colleagues<br>Interim proposal to mitigate short term support concerns for LIMS with longer term solution in discussion with ICS<br>IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical areas | 6.4C | A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts |
| 6.5A | Prohibitive cost of software licensing<br>Increasing change of software licensing to subscription models | 6.5B | 2022/23 capital plan, including external Frontline Digitisation funding<br>Procurement of an EPR with a high level of functional scope that reduces the number of siloed IT systems required<br>Procurement/implementation of shared IT systems between organisations<br>Maximising use of nationally provisioned IT systems | 6.5C | IT to support current or future business needs outstrips the Trust's capacity to finance it |
| 6.6A | Computer infrastructure environmental risks | 6.6B | 2022/23 capital plan, including external Frontline Digitisation funding<br>System approach to data centre provision being formulated | 6.6C | A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts |
| 6.7A | Computer patching risks | 6.7B | 2022/23 capital plan, including external Frontline Digitisation funding | 6.7C | A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT |

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| | | | | | systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts |

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 6.3A | National funding has not yet been fully secured to deliver the EPR; there is no ICS funding available to fund an EPR | 6.3A, 6.4A | The national timetable for securing national investment is currently too lengthy and will lead to interim IM&T risk |
| 6.1A, 6.2A, 6.4A, 6.5A, 6.6A, 6.7A | Longer term capital and revenue investment programmes are required to ensure that digital infrastructure refresh cycles, improvements and maintenance are sustained | 6.1A, 6.2A, 6.3A, 6.4A, 6.5A, 6.6A, 6.7A | Inability for the System approach, and the provider-level governance to support it, to a common, single shared IM&T service to be agreed and implemented will reduce ability to mitigate the risk |
| 6.1A, 6.4A | In year reduction in funding for digital will reduce intended progress around cyber-security measures and jeopardise tactical replacement of end-of-life systems | | |
| 6.4A, 6.5A | There are a large number of IM&T systems that require developments of procurement, that are highlighted as a significant risk on the digital prioritisation matrix for which there is no current capital or revenue availability | | |
| 6.3A | Sufficient capacity within clinical, operational and corporate services to deliver a large scale EPR implementation | | |
| 6.1A, 6.2A, 6.3A, 6.4A, 6.5A, 6.6A, 6.7A | Short-term requirement to achieve CIP without real efficiencies deliverable through a shared IM&T service will compromise the ability to mitigate the risk | | |

**Action Log: (actions identified to achieve target risk score)**

| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
|---|---|---|---|---|
| 6.1A, 6.2A, 6.4A, 6.5A, 6.6A, 6.7A | Ensure that all high-risk IM&T investment is programmed into the capital and revenue business planning process at both Trust and ICS level | DTP/CFO | 1.4.2023 | Secured for 2022/23 with additional external capital. |
| 6.3A | Successfully secure EPR funding from the national team | DTP | 1.12.2022 | Secured – subject to FBC but all key criteria including affordability now met and process for regional/national OBC approval underway. |
| 6.1A, 6.2A, 6.3A, 6.4A, | Ensure sustainable delivery of all key systems by working in partnership with the ICS Digital Leadership | DTP | 1.4.2023 | Fully engaged with all ICS partner organisations. A 'system-first' approach is being pursued. |

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| 6.5A, 6.6A, 6.7A | | | | |
| 6.4A | Mitigate LIMS support risk by migrating the database onto a supported platform and financing extended support for the servers that are unable to be upgraded.<br>In parallel, initiate a competitive bid procurement, in collaboration with the ICS, for a replacement LIMS as an alternative should it be clear that an EPR and any associated LIMS would not be in place before the end 2024. | DTP | 1.2.2023 | Progressing to plan. |

| **Risk Summary** | | | | | |
|---|---|---|---|---|---|
| **BAF Reference:** | **7. BUILDING A BRIGHTER FUTURE (BBF)** | | | | |
| **Objective:** | 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 | | | | |
| Internally Driven: ✓ | Externally Driven: ✓ | | | | |
| **Responsible Executive:** | Director of Transformation and Partnerships | **Committee:** | Building a Brighter Future Committee | **Last Updated:** | June 2023 |

| **BAF Risk Scoring** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
| | **Aug 22** | **Nov 22** | **Jan 23** | **March 23** | **May 23** | **May 22** | The availability of a national funding for cohort 4 |
| **Likelihood** | 3 | 3 | 3 | 3 | 3 | n/a | |
| **Consequence** | 5 | 5 | 5 | 5 | 5 | n/a | |
| **Risk Score** | 15 | 15 | 15 | 15 | 15 | n/a | |

| **Risk Scoring Analysis** | | | | | |
|---|---|---|---|---|---|
| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
| 7.1A | Availability of central funding and political support to the original programme | 7.1B | BBF programme office and capital development team are working through a range of different scenarios should capital funding not be made available at a national level. | 7.1C | Should funding not be made available the Trust still requires significant capital investment on its estate infrastructure and as such, would then pursue one of the scenarios previously highlighted. |
| 7.2A | Availability of the specialist support within the BBF programme team to deliver a project of this magnitude and complexity. | 7.2B | The Programme office has a well-developed recruitment and retention strategy that highlights requirement for external specialist support in areas such as design, cost advise and legal services. The team will be able to draw on this expertise as required. | 7.2C | The costs associated with the external support would be detailed in any 'seed' funding allocation and would be agreed with the national team in advance of the requirement for the specialist support |
| 7.3A | Timeline for programme completion | 7.3B | The programme office has developed a range of scenarios associated with the delivery of the programme and these have been shared with the BBF Committee | 7.3.C | The inflationary pressures of the programme will continue to increase without the required clarity from the national team on timetable and funding allocation. These costs would be funded centrally. |
| 7.4A | National team resourcing the 'seed' allocation not in line with our timetable | 7.4B | This matter is nearing resolution for 23/24 which will confirm the allocation of £1.06m. This figure will need to be supplemented with a further £361,000 from the national team to support the completion of the Site Enabling FBC. The national team are aware of the Trust requirement in this regard. | 7.4.C | The Trust would not able to complete the Site Enabling Full Business Case to the required fundamental criteria standards, and the programme would be delayed as a result |
| 7.5A | Planning the clinical and operational support within the Trust to support the delivery of the programme plan from 1/4/23 | 7.5B | This matter is under review with the SRO and Health and Care Strategy Director and will form part of the 'seed' funding requirements for 23/24. | 7.5C | The ability of the Trust team to deliver the BBF programme will be reviewed by the NHP national team, so in order to avoid 'step in' it is essential that the programme is able to benefit from the required clinical and operational support. |

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| 7.6A | Inflationary cost pressures in preferred option | 7.6B | The national team will ensure that the inflationary pressures associated are funded through the 'target cost modelling' review that will be undertaken as part of the approvals process. | 7.6C | The impact would be significant as the Trust would be required to reduce the scope of the construction project in order to absorb the inflationary pressure on the project. |
| 7.7A | Alignment of strategic direction with the acute services review in Devon and any associated consultation process. | 7.7B | The Programme office is sighted on the requirement for the Outline and Full Business Case(s) to be consistent with the recommendations made within the Provider Acute Sustainability Programme. | 7.7C | The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the Regional office. The programme would be delayed as a result. |
| 7.8A | Support from the One Devon ICB for the business cases required to secure approval | 7.8B | The Programme office will be developed an engagement strategy for ensuring that the business cases are fully supported by the ICB in a timely manner. | 7.8C | The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the Regional office. The programme would be delayed as a result. |
| 7.9A | Ability to deliver the site enabling and support services elements for the project within the timetable to enable main construction commencing in 2025 | 7.9B | The Trust are not able to progress the scheme without the required support from the national new hospital team.<br>The national team have confirmed that a funding announcement will confirm both allocation and timetable. | 7.9C | The programme office had confirmed that the risk associated with the programme not being able to complete by 2030 are now seen as high. |
| 7.10A | Availability of contractors and materials to complete programmes of work and potential lengthy lead in times. | 7.10B | Capacity does need to be developed in order for the scale of the investment to be delivered, and this is being progressed at a national level. | 7.10C | The development of the hospital 2.0 concept will mean that this risk is held at a national level. Therefore, the cost and time implications of this issue are being managed centrally |

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 7.1A | • Slippage in national programme timeline and the release of seed funding has an implication for the following:<br>○ Detailed design for site enabling<br>○ Integrated assurance strategy for programme<br>○ Workforce planning | 7.1B | External<br>• Lack of assurance in relation to NHP cohort 4 capital funding and timetable at a national level<br>• Due to the delays in securing the approval to the National programme Business Case, the NHP timetable subject to regular change. |

**Action Log: (actions identified to achieve target risk score)**

| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
|---|---|---|---|---|
| 7.1A | Site Enabling Fees – Programme Office will seek approval for the additional 'seed' funding required to complete the Site Enabling Full Business Case and the funding required for the subsequent works. | Director of Transformation & Partnerships | Submission – June 23<br>Approval - Sept 2023 | |
| 7.1B | Action to address lack of assurance in relation to capital funding and national timetable delay | Director of Transformation & Partnership | Ongoing | Bandwidth of capital allocation has now been confirmed . Interim NHP project director has now been appointed and the BBF programme office have commenced discussions with the postholder to |

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|---|---|---|---|---|
| | | | | agree next steps in relation to progress of the programme |
| 7.2A | Site Enabling Business Case(s) – the Outline and Full Business Case(s) will be approved by the Trust Board and presented to the NHP National team | Director of Transformation & Partnerships | OBC – October 2023 | |
| 7.3A | Drumbeat 2.0 – the desk top research to evaluate best practice across our clinical specialities will be completed and reported to the BBF Committee | Health and Care Strategy Director | September 2023 | |
| 7.4A | Planning scenarios – the respective planning scenarios associated with the funding allocation will be shared with the BBF Committee | Director of Transformation & Partnerships | September 2023 | |
| 7.5A | Masterplanning – the outcome of the peer review master planning exercise will be presented to the BBF committee | Director of Transformation & Partnerships | September 2023 | |
| 7.6A | Digital Outline Business Case – Ensure that the EpR Outline Business Case secures national approval | Director of Transformation & Partnerships | July 2023 | |
| 7.7A | Digital procurement – ensure that procurement process associated with the EpR is completed in accordance with agreed project timetable | Director of Transformation & Partnerships | October – 2023 | |
| 7.8A | Digital Full Business Case – ensure that the EpR Full Business Case is completed in accordance with the agreed project timetable | Director of Transformation & Partnerships | December – 2023 | |
| 7.9A | EpR Readiness / Delivery -ensure that the Trust is in a position to manage the implementation process of the new EpR system | Director of Transformation & Partnerships | Readiness - July 2024 Delivery from August 2024 | |
| 7.10A | EpR go live – the go live for the new EpR will take place in accordance with agreed project timetable | Director of Transformation & Partnerships | August 2025 | |

## Risk Summary

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|---|---|
| **BAF Reference:** | **8. TRANSFORMATION AND PARTNERSHIPS** |
| **Objective:** | To implement Trust plans to transform services, using digital as an enabler, to meet the needs of our local population |
| Internally Driven: ✓ Externally Driven: ✓ | |

| **Responsible Executive:** | Director of Transformation and Partnerships | **Committee:** | Finance, Performance and Digital Committee | **Last Updated:** | May 2023 |
|---|---|---|---|---|---|

## BAF Risk Scoring

| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
|---|---|---|---|---|---|---|---|
| | **Jul 22** | **Nov 22** | **Jan 23** | **Mar 23** | **March 24** | **May 22** | Significant challenges in Quality, Safety, Performance and Financial performance requires the delivery of a large-scale transformation programme with benefits delivered in 23/24.<br><br>Recruitment to the Improvement and Innovation team capacity is progressing but there remains a lack of capacity and capability across the Trust and ICS to deliver these changes.<br><br>A significant and ambitious programme of change is required across the ICS and this is in addition to Trust wide schemes, placing additional pressure on scarce improvement expertise.<br><br>There isn't a unified and single approach to a standardised and co-ordinated programme of change, implemented reliably across the ICS.<br><br>Basic IT and estate infrastructure is poor and hampers significant levels of transformation at pace |
| **Likelihood** | 5 | 4 | 4 | 4 | 3 | n/a | |
| **Consequence** | 4 | 4 | 4 | 4 | 3 | n/a | |
| **Risk Score** | 20 | 16 | 16 | 16 | 9 | n/a | |

## Risk Scoring Analysis

| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
|---|---|---|---|---|---|
| 1.1A | Inadequate improvement and innovation capacity within the Trust | 1.1B | Oversight of recruitment through new Transformation Group. | 1.1C | Harm to patients arising from services not delivering most effective care |
| 1.2A | Lack of ICS wide improvement capability to create an engine room for system change | 1.2B | Peninsula Acute Provider Collaborative Board mandated the development of an investment proposal. | 1.2C | Trust does not deliver required improvements at pace to meet SOF4 exit criteria |
| 1.3A | Lack of operational and clinical leadership capacity | 1.3B | Oversight of delivery of the outcomes from coaching programme, delivered through Transformation Group and planned to be reported to BBF Committee from July 2023 | 1.3C | Regulatory action for safety, quality and performance standards |
| 1.4A | IT infrastructure is inadequate for significant transformation | 1.4B | EPR Digital business case in approval pipeline with National team, oversight through Exec Advisory Group & BBF committee | 1.4C | Low morale and increasing fragility in the workforce as a result of moral injury |
| 1.5A | Estate infrastructure is inadequate for significant transformation | 1.5B | FPDC oversight of TIF capital developments and opening of new AMU. BBF committee oversight of NHP programme delivery | 1.5C | |

| | | | | | |
|---|---|---|---|---|---|
| 1.6A | Too many competing priorities across the ICS and Trust | 1.6B | Regain and Renew plan provides a framework for focus on most critical Trust / ICS priorities – monitored by TMG | | |
| 1.7A | Operational and Clinical ownership and delivery of all transformation portfolios | 1.7B | Executive oversight of delivery of Transformation Programmes within their governance oversight frameworks (e.g Safety and Quality to QIG/QAC) oversight of overall programme of change proposed will sit with new BBF Committee TOR – implementation in July 2023. | | |

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 1.3A | Deficits in operational management and clinical capacity for improvement, not yet addressed through the full implementation of the new governance and leadership structure | 1.3A | ICS PASP programme delivery under-resourced |
| 1.3A | Pace of capability building is consistent with early phase of investment profile, does not provide adequate capacity for significant transformation in 23/24 | 1.3A | ICS Fragile services delivery under-resourced |
| 1.4A | IT infrastructure investments will not delivery the level of digital capability or business intelligence to drive significant levels of transformation in 23/24 – due to implementation of EPR | 1.2A | Clear plan that links ICS recovery and medium term 3 year plan needs to be developed and agreed |

**Action Log: (actions identified to achieve target risk score)**

| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
|---|---|---|---|---|
| 1.1A | Recruit to full establishment of business case | DTP | Oct 2023 | 70% of posts recruited to. Further posts advertised. |
| 1.7A, 1.7B | All transformation portfolios led by Executive leads and delivering against agreed milestone actions with robust monitoring | DTP | Sept 2023 | |
| 1.3A | Capability programme delivery for 23/24 | DTP | Mar 2024 | |
| 1.3A | Delivery of new leadership structure and accountability framework | COO | TBC | To be linked to COO/CNO workplan |
| 1.2B | Produce business case for ICS fragile services engine room of capacity | DTP | June 2023 | |

| Risk Summary | | | | | |
|---|---|---|---|---|---|
| **BAF Reference:** | **9. INTEGRATED CARE SYSTEM** | | | | |
| **Objective:** | Create the conditions for collaborative working and delivery of shared goals in partnership with the ICS | | | | |
| Internally Driven: Externally Driven: ✓ | | | | | |
| **Responsible Executive:** | Director of Transformation and Partnerships | **Committee:** | Board of Directors | **Last Updated:** | May 2023 |

| BAF Risk Scoring | | | | | | |
|---|---|---|---|---|---|---|
| **Current Position** | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
| | **Nov 22** | **Jan 23** | **May 23** | **April 24** | **May 22** | The Trust partnerships across the ICS are critical in securing improvements in the delivery of services for local people. The risk in sustaining the delivery of clinical and back office services, has been a priority for the Trust, however there have been multiple attempts to develop the level of collaborative partnerships that have failed to deliver the appropriate level of transformation. |
| **Likelihood** | 4 | 4 | 4 | 2 | n/a | |
| **Consequence** | 4 | 4 | 4 | 4 | n/a | |
| **Risk Score** | 16 | 16 | 16 | 8 | n/a | The ICS Acute provider Collaborative Programme has greater level of formal Board sign up and commitment. The Trust is fully engaged in the delivery of this strategic change. |

| Risk Scoring Analysis | | | | | |
|---|---|---|---|---|---|
| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
| 1.1A | PASP programme progress delayed through recent industrial action | 1.1B | Proposal for change developed for presentation to Trust Boards agreed by PAPC | 1.1C | Unable to influence the direction of change in the local health economy. |
| 1.2A | Internal capacity to ensure that teams are supported to fully engage in the development and delivery of system solutions | 1.2B | Oversight through new Transformation Group. Engagement delivered through Trust Strategy Group and TMG | 1.2C | Mis-alignment of system changes with the needs of the community and poor-quality outcomes/patient experiences. |
| 1.3A | A transformation plan that outlines a 3 year plan from immediate recovery actions to broader transformational change is not developed and owned by all partners | 1.3B | Proposal in development for discussion with Chair of ICB Strategy and Transformation Group, | 1.3C | Delays in decision-making. |
| 1.4.A | Leadership and programme management capacity to deliver significant transformational change, including PASP, Fragile Services and back office collaboration | 1.4B | PAPC commissioned work to address additional resource requirement | 1.4C | Damage to the Trust's reputation. |
| 1.5A | Challenging timelines for engagement to optimise delivery | 1.5B | PASP oversight of engagement plan, Trust Strategy Group will oversee implications, wide engagement through TMG, and new BBF Committee provides oversight | | |
| 1.6A | Lack of LCP clear mandate and resourcing from the ICB, exacerbated by the ICB restructure | 1.6B | Escalated to ICB | | |
| 1.7A | Oversight of Partnerships agenda needs to be strengthened | 1.7B | Proposal to extend the scope of BBF Committee to provide oversight for ICS partnerships agenda. Intention to seek approval for implementation July 2023 | | |

| Gaps in control/assurance | | | |
|---|---|---|---|
| **Internal** | | **External** | |
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 1.6A | Realignment of capacity for delivery of ICS partnership ambitions | 1.6A | ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. |
| 1.3A | Plans not of sufficient maturity to understand all implications for the Trust | 1.6A | Devon System Health and Care Strategy not mature |
| 1.3A | System planning and delivery arrangements not yet mature | 1.6A | Maturity of relationships and collaborative working arrangements developing |
| 1.6A | Lack of capacity | 1.7A | Development of formal reporting process through system and organisational governance |
| | | 1.7A | Implications of revised governance arrangements on FT governance and decision making |
| | | 1.3A | Financial Plan/Devon System Health and Care Strategy |

| Action Log: (actions identified to achieve target risk score) | | | | |
|---|---|---|---|---|
| **Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
| 1.1A | Provide system leadership in the development of the PASP proposal | CEO | May 2023 | |
| 1.3A | Provide system leadership in the Devon Recovery plan | CEO | Ongoing | |
| 1.4A | Ensure Executive leadership capacity for the system aligns with Trust requirements for internal delivery | CEO | Ongoing | |
| 1.4A | Involvement and influence of outputs from ICS Clinical Leadership Group. | CMO/CN | Ongoing | |
| 1.2A | Continued and regular communication and engagement with staff, CoG and stakeholders (Executive team). | CEO | Ongoing | |
| 1.2A | Regular meetings and relationship building with primary care and ICS leaders to ensure effective communication and influence with regards to ICP. | DTP | Ongoing | |

| Risk Summary | | | | | |
|---|---|---|---|---|---|
| **BAF Reference:** | **10. GREEN PLAN/ENVIRONMENTAL, SOCIAL AND GOVERNANCE** | | | | |
| **Objective:** | To deliver on our plans and commitments to environmental sustainability and decarbonisation, as set out in the Trust Green Plan. | | | | |
| Internally Driven: ✓ Externally Driven: | | | | | |
| **Responsible Executive:** | Deputy Chief Executive supported by Director of Environment | **Committee:** | Board | **Last Updated:** | May 2023 |

| BAF Risk Scoring | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Current Position** | | | | | **Target Position** | **Year on Year** | **Rationale for Risk Level** |
| | **Jul 22** | **Nov 22** | **Jan 23** | **Mar 23** | **Sept 23** | **May 22** | There is a risk that the Trust will fail to meet Green Plan objectives and statutory sustainability targets due to insufficient capital or revenue resources, and lack of prioritisation in decision making.<br><br>This could lead to:<br><br>Delay to the decarbonisation of our estate, inability to meet the NHS Net Zero Carbon target deadlines and potential conflict between Trust sustainability commitments and other Trust priorities.<br><br>Damage to public confidence, statutory non-compliance, regulatory breaches. |
| **Likelihood** | n/a | n/a | n/a | 4 | 3 | n/a | |
| **Consequence** | n/a | n/a | n/a | 3 | 2 | n/a | |
| **Risk Score** | n/a | n/a | n/a | 12 | 6 | n/a | |

| Risk Scoring Analysis | | | | | |
|---|---|---|---|---|---|
| **Aggravating Factors increasing risk profile:** | | **Mitigating Factors (internal controls):** | | **Impact of risk occurring:** | |
| 10.1 A | Infrastructure across the estate is aged and not environmentally efficient. | 10.1 B | Utilisation of capital allocation to replaced assets beyond economical repair. The replacement process considers the opportunity for replacement with environmentally efficient alternatives | 10.1 C | Trust will not meet its decarbonisation commitments as outlined in the Green Plan<br><br>Reputational damage for the Trust |
| 10.2 A | Modern, renewable methods of powering sites across the estate have not been routinely employed | 10.2 B | Utilisation of capital allocation to replaced assets beyond economical repair. The replacement process considers the opportunity for replacement with environmentally efficient alternatives<br><br>Head decarbonisation plan has been developed to determine the optimal decarbonisation pathway | 10.2 C | Trust will not meet its decarbonisation commitments as outlined in the Green Plan<br><br>Reputational damage for the Trust<br><br>Trust will continue to operate using assets which do not deliver environmental or financial efficiency |
| 10.3 A | The existing infrastructure is aged to a point where assets cannot be easily added or replaced with environmentally efficient ones (due to the condition of the infrastructure on to which they would be attached) | 10.3 B | NHP will address some of the underlying issues in relation to the age and capacity of the current infrastructure, allowing for more environmentally efficient ad-ons | 10.3 C | Trust will not meet its decarbonisation commitments as outlined in the Green Plan<br><br>Reputational damage for the Trust<br><br>Trust will continue to operate using assets which do not deliver environmental or financial efficiency |

| 10.4 A | Sufficient focus and priority is not given to the implementation of the Trust Green Plan as resource availability is limited and focussed on operational delivery and recovery | 10.4 B | Trust Green Plan outlines its environmental mission and associated plans and has been shared with Trust staff<br><br>Sustainability and Wellbeing Group has been setup, led by the Workplace Director focussed on enhancing engagement and input into the green agenda across. This is connected to locality and Devon-wide sustainability plans.<br><br>Net Zero lead appointed to board | 10.4 C | NHS activities are responsible for 6.3% of England's total carbon emissions, and 5% of total air pollution. This has direct consequences for health-related spending<br>Reputational damage for the Trust |
|---|---|---|---|---|---|

**Gaps in control/assurance**

| **Internal** | | **External** | |
|---|---|---|---|
| **Risk analysis reference:** | | **Risk analysis reference:** | |
| 10.4A | Lack of dedicated resource and integrated working to deliver and identify initiatives in specialist areas, such as supply chain and clinical activities. | 10.4A | Uncertain funding to implement decarbonisation initiatives particularly where these may cause a cost pressure. |
| 10.4A | Lack of sustainability awareness at TSDFT from potential new recruits, new starters and existing staff, such as Green Plan objectives and expectations from staff whilst working at the Trust | 10.4A | Uncertainty around when and what measures need to be implemented to achieve NHS Carbon Footprint Plus NZC targets, particularly for supply chain emissions. |

**Action Log: (actions identified to achieve target risk score)**

| **No. Risk analysis reference:** | **Action required:** | **Executive Lead:** | **Due Date:** | **Progress Report:** |
|---|---|---|---|---|
| 10.3A/10.4A | Develop a robust communication plans for staff and embed ownership | CFO | 01/08/2023 | Sustainability and wellbeing group (SWBG) stood up<br>Green champions currently being appointed<br>90-day plan as part of SWBG in place |
| 10.4A | Finalise plans for all target actions | CFO | 01/05/2023 | Will be led by the SWBG |
| 10.3A | Develop dashboard of measures | CFO | 01/08/2023 | Will be led by SWBG |
| 10.4A | Embed clear sustainability measures across supply chain network | CFO | 01/01/2024 | Ongoing – further work to engage with procurement team required |
| 10.4A | Climate change impact assessment for Trust owned and leased premises | CFO | 01/08/2023 | Shortlisting contractors – further updates in July 2023 |
| 10.2A | Promote and support the use of electric cars among staff members | CFO | 01/03/2024 | Forms part of green travel plan and a key focus for SWBG |
| 10.2A | Place opportunity to market for provision of locally generated renewables directly to main hospital site | CFO | 01/06/2023 | Completed – published to market 18th May 2023. |

| | | | | |
|---|---|---|---|---|
| | Attain Biodiversity Benchmark from The Wildlife Trust in recognition of habitat preservation on site | CFO | 01/04/2025 | Work to enhance habitat preservation methods has begun (bug hotels, wildseed meadows etc), biodiversity policy under construction and benchmark framework provided |

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Torbay and South Devon NHS Foundation Trust

**DATIX RISK MODULE REPORT**

(Exceptions highlighted in Yellow.)

| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description<br>Cause:<br><br>Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes<br>Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Action Point/Plans relating to Risk<br>Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes<br>Last 3 entries minimum. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1083 | 01/01/2016 | Corporate Level Risk | Estates | Karen Robertson | Jake O'Donovan | Chief Finance Officer (David Stacey) | Financial Risk | Estates Mngt | Site Non-Specific | Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care. | Cause: Lack of adequate long-term capital funding to ensure backlog maintenance is adequately addressed.<br><br>Effects:<br>A. Failure of aged plant and deteriorating building fabric, resulting in unplanned cancellation of clinical services.<br>B. Potential impact on ability to meet RTT and other contractual clinical standards.<br>C. Increased risk of harm to staff, patients or members of the public from failing infrastructure.<br>D. Increased estate maintenance costs (revenue and capital) and risk of financial penalties due to clinical breaches.<br><br>Linked to Risks:<br>DRM ID No 2353 - Cellular Pathology Portacabin No Longer Fit for Purpose. (16)<br>DRM ID No 2542 - Potential Failure of Theatres DSU 3 & Ophthalmology Ventilation Units. (16)<br>DRM ID No 2720 - Leaking Roofs Across Torbay Hospital Site (20)<br>DRM ID No 2718 - Inability To Expand Clinical Services Due To Lack Of Space.(15)<br>DRM ID No 2719 - Chilled Water System Failure (16)<br>DRM ID No 2836 - Telemetry System Upgrade. (Used for looking for causes of collapses & side effects of medication.) (16)<br>DRM ID 3192 - Issues With Inadequate Lighting Sources at Torbay and Newton Abbot for Max Fac Outpatients (15)<br>DRM ID 3193 - Clinic Environment For Max Fac Patients In Alternative Accommodation (15)<br>DRM ID 3473 (20) Mortuary Capacity Consistently Exceeding 100% Standard Capacity<br>DRM ID 2429 Ward Kitchens Environment in Acute and Community Settings in Need of Updating - 26 locations identified.(16) | Catastrophic | Almost Certain | 25 | 1. Risk assessment, prioritisations and approval process in place to manage highest risks. Highest risk elements prioritised in the capital programme, as funding will allow.<br>2. Increased financial contingency built into capital programme to respond to unplanned critical estates failures.<br>3. Increased maintenance for key areas.<br>4. Business continuity plans in place to respond to potential loss of infrastructure.<br>5. Robust planned preventative maintenance regime in place.<br>6. Estates Planned Prevenative Maintenance performance and compliance status and critical failures reported and monitored monthly via Capital Infrastructure and Environment Group; Finance, Performance and Investment Committee; Infection Prevention and Control Committee; exceptions to Trust Board meeting.<br>7. Statutory Estates Roles and Responsibilities appointed and tracked monthly.<br>8. Annual review of mandatory and statutory systems compliance by externally appointed Authorising Engineer(s).<br>9. Board has approved annual capital programme based on actively considered risks versus maintaining a cash balance.<br>10. Trust has submitted Business Case for new acute hospital facilities. | 1. Insufficient funds available to address all high priority risks over a 5-year period.<br>2. Equipment and plant continues to fail and due to age, cannot always be repaired.<br>3. Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities.<br>4. Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity. | 30/06/2023 | Catastrophic | Almost Certain | 25 | [05/04/2023 12:57:05 Paul Hayman] Works for new CT_RT scanner commenced and Northcott Hall and Embankment demolished as part of early site clearance works for BBF.<br>[17/01/2023 14:02:52 Paul Hayman] BBF Project aware considering impact of retention of Old Hospital / Podium blocks which are old and require significant refurbishment.<br>5-10 Year Capital plan will also help to address Backlog elements.<br>AMU completed and scoping work for TIF and Endoscopy units underway to provide 4,500 additional cases per year - (Ophthalmology).<br>Consideration of allocation of funds for patient / colleagues experience and safety. To be reviewed end March 2023.<br>[05/05/2022 08:46:54 Paul Hayman] Significant Capital Project work helping to improve system resilience, however, significant issues remain to be addressed. Backlog Capital Investment overall for 2021-22 at £5.963m, plus a further £1.15m investment in ongoing AMU, MRU and ED Phase 2 works. Provisional Backlog Figure for Acute site now stands at £52.2m. Further bid in train for 2022-23 capital round. | Catastrophic | Possible | 15 | | | | | | |
| 1159 | 18/09/2012 | Corporate Level Risk | IT Operations and Informatics | Gary Hotine | Adel Jones | Director of Transformation and Partnership (Adel Jones) | Information and Communications Technology Risk | Administration | Site Non-Specific | Current IT Systems And Infrastructure Will Not Meet Future Demands. | Cause: Lack of available capital funding to spend on IT infrastructure and IT Systems.<br><br>Effects:<br>A. Failure of key IT infrastructure and IT systems resulting in impact on service delivery.<br>B. Lack of cyber security investment may expose the Trust to risk of fines equal to 4% of Turnover or £ capped at £17M following a successful cyber-attack similar to the May 2017 "Wannacry" attack. NHS Digital (for NHS England) are highlighting the number of CareCERTs they have mandated that Trusts have mitigated.<br>C. Inability to meet future statutory or regulatory requirements around reporting.<br>D. Possible impact on clinical systems impacting patients /service users.<br>E. Failure to meet future CQC registration requirements unless the Trust can achieve "minimum digital functionality" as detailed in the Accelerating Digital Healthcare white paper of October 2020.<br>F. Inability to achieve the Government's requirement (2022) of 100% having or implementing EPRs by 2025.<br><br>Note: Our plans are predicated on an on-going capital investment plan to ensure optimum performance of service.<br><br>Linked to Risks:<br>1168 - National Programme for IT HSCIC.<br>1174 - Increasingly Software Companies Are Changing Their Licensing.<br>2019 - Symphony IT System for Emergency Dept not Reliably Sending Safeguarding Referrals to Allocated Drive.<br>2696 - WinPath V5 Incompatibility Risk.<br>2781 - Maternity Information System<br>2830 - Computer Hardware Risks (Replaces 1173 & 2280)<br>2831 - Computer Infrastructure Risks (Replaces 1164, 2275, 1166 & 1185)<br>2838 - Potential Failure to Meet Cyber Security and Information Governance Standards Set by NHS Digital. (Replaces 1158 & 1161)<br>2864 - Failure of the Trust Dell Storage Platform During Routine Patching Maintenance.<br>3309- Patient Admin System Becomes Unsupported<br>2161 - Viewpoint System End of Product Life | Catastrophic | Almost Certain | 25 | 1. ICT Strategy with supporting policies and procedures e.g. Business Continuity Plans.<br>2. Well-developed IM&T service, linked strategically with ICS digital delivery strategy/plans.<br>3. Upgrade current key systems to mitigate effect.<br>4. IT Projects and Programme governance in place and linked to organisation's executive groups. IM&T Group reports, reports to Finance, Performance and Digital Committee.<br>5. Investment planning to maintain and develop infrastructure capacity.<br>6. Continued IM&T Strategic investment. Risk assessment based on need and prioritised accordingly.<br>7. Continual review of emerging technology and adoption where suitable and funding permits.<br>8. Minimising critical failure.<br>9. Management of failure.<br>10. Internal audit reviews.<br>11. Actions following Information Commissioners Office visit (Sept 2015 & follow ups in 2018 and 2022).<br>12. Retention of individuals or contractors with requisite skills and experience to provide tactical software enhancements to plug gaps in legacy systems.<br>13. PC deployment programme.<br>14. Replacement data network.<br>15. Plan to invest significantly in IT linked to digital strategy as a key enabler. Supporting Digital Strategy adopted by Trust Board in September 2020. EPR OBC approved in 2021. FBC approval expected 2023. | Ctrl's 5.6.7.13 & 14 Insufficient funds allocated to reduce risks (2022 example - inability to fund the £1.4m EUD scheme).<br>Ctrl 15 delivery of the key recommendations in the digital strategy | 01/10/2023 | Catastrophic | Almost Certain | 25 | [09/05/2023 10:19:44 Gary Hotine] Risk scoring reviewed<br>[26/09/2022 18:40:05 Gary Hotine] Reviewed and updated controls and gaps in controls.<br>[06/09/2022 10:35:49 Joshua Langdon] Network & Server infrastructure is currently in a good state and is supported by both supplier and HIS.<br>Desktop devices (EUD) are now coming up to the end of their warranty period. Capital proposal for £1.4m CapEx has been rejected for FY 2022/23 which will mean that we will be running 'Warranty +1' which introduces additional risk if our devices experience failure.<br>Furthermore, our current Desktop device estate is currently not fit for purpose based on the technical requirements for any future EPR (Electronic Patient Record) system. This risk has been highlighted to BBF and the Capital Planning group. | Major | Possible | 12 | | | | | | |
| 2996 | 01/02/2021 | Corporate Level Risk | Finance | Dave Stacey | Dave Stacey | Deputy Chief Executive Officer - Dave Stacey | Financial Risk | Finance | HQ, Regents House | Financial Sustainability Risk Rating for 22/23 and 23/24 | Cause: Lack of Improvement in underlying financial position of the Trust and medium term financial sustainability.<br><br>Effect:<br>1. Certain Failure to deliver 2023/24 deficit financial plan<br><br>2. Failure to address underlying financial performance of the Trust over £50m recurrent deficit, and failure to deliver the agreed financial plan for 2023/24<br>3. Reputational risk to the Trust and impact on ICS overall financial sustainability. All provider in the ICB now are under SOF 4 regulatory special measures<br><br><br>Linked to Risks:<br>2997 Overspend On Variable Staffing - 2021/22 Budget Levels.<br>2402 Increasing Costs Of High Value Drugs & Devices | Catastrophic | Almost Certain | 25 | 1. Tightened internal financial governance and the adoption of the Budget Spending and Investment Protocols adopting a budget envelope approach<br>2. Jointly with the ICB to formulate sustainable Medium to long Term Financial Plan (MTFP/ LTFP) and financial recovery strategy and continue to improve 23/24 financial draft plan before final submission to NHSEI<br>3. In-depth discussion on Financial Performance reports at operational governance meetings such as IGG, Executive meetings, Recovery Group (DCEO-chaired), System Financial Recovery Board, Finance, Performance and Digital Committee (FPDC) and Board.<br>4. Deep dives undertaken at Finance, Performance and Digital Committee.<br>5. Programme office and management function established, monitoring and reporting delivery of schemes.<br>6. Regular updates provided to the system Finance Working Group and system financial recovery board, progression of ICS wide savings initiatives.<br>7. Exec-led performance monitoring of delivery systems.<br>8. CIP targets established in detail at service level, with Executive sponsors and management leads identified for schemes.<br>9. External support from Deloitte on drivers of deficit in 2023/24 commissioned by ICB<br>10. CQC Use of Resources inspection approach<br>11. Benchmark data such as NCCI, Model Hospital, PLICS<br>12. the Delivery Director for improvement are now post (Jan 2023) | 1. Lack of regular and coherent productivity reviews of clinical services and action plan to address the issues<br>2. Interruptions to meetings cycles (routine governance) due to operational pressures.<br>3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing | 31/07/2023 | Catastrophic | Almost Certain | 25 | [26/05/2023 09:29:27 Dave Stacey] Updated DS May 2023<br>[30/01/2023 13:34:45 Tian Ze Hao] Risk updated for the current and coming financial year (23/24). We are in the process of submitting a joint acceptable operational plan with the ICB in Feb 2023.<br>[20/06/2022 13:31:24 Tian Ze Hao] Risk and gap in controls updated following operational plan resubmission in June. | Catastrophic | Likely | 20 | | | | | | |

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| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description<br>Cause:<br><br>Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes<br>Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes<br>Last 3 entries minimum. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3309 | 03/11/2021 | Corporate Level Risk | Informatics Systems | Gary Hotine | Adel Jones | Director of Transformation and Partnership (Adel Jones) | Information and Communications Technology Risk | Administration | Other not listed | Patient Admin System Becomes Unsupported | Cause: The PAS is obsolete and support will cease.<br><br>Effect: The Trust cannot function and deliver its prescribed services and functions without a PAS | Catastrophic | Almost Certain | 25 | 1. Early identification of the issue so that re-procurement and implementation can be accomplished (18 months) | 1. EPR business case approval and the funding source identified needs to be achieved by April 2023 to avoid a tactical PAS replacement.<br>2. HIS resourcing business case approval, or an agreed System solution required to ensure capacity exists to achieve the PAS replacement from April 2022. | 03/07/2023 | Catastrophic | Almost Certain | 25 | [04/04/2023 17:14:00 Gary Hotine] No change - EPR OBC progressing but until procurement leads to preferred bidder with clear implementation timescale the risk score will remain the same.<br>[26/09/2022 18:33:34 Gary Hotine] Updated to reflect progress on formal support extension.<br>[15/02/2022 13:22:00 Gary Hotine] Updated the action re: obtaining a support extension | Catastrophic | Rare | 5 | The business case for additional HIS resources provides the minimum resources to enable the HIS to maintain BAU services, and increase the project capacity required to implement a PAS which is a major undertaking. | Adel Jones | 01/02/2024 | | | [26/09/2022 18:31:33 Gary Hotine] Taken to Execs and FPDC twice but no funding solution available |
| | | | | | | | | | | | | | | | | | | | | | | | | | Obtain formal extension for support from supplier, including for the Microsoft and Intersystems components upon which the PAS is built. | Gary Hotine | 01/01/2025 | | | [02/05/2023 13:15:48 Gary Hotine] Supplier has agreed that at least 2 years notice will be provided<br>[08/03/2023 10:48:17 Gary Hotine] Supplier maintains the agreed position.<br>[07/03/2023 08:22:45 Gary Hotine] Daedalus have confirmed that 2 years' notice will be provided when the platforms from ISS are to become unsupported, but cannot put in writing. |
| 3274 | 21/09/2021 | Corporate Level Risk | Finance | Dave Stacey | Dave Stacey | CEO (Liz Davenport) | Financial Risk | Finance | HQ. Regents House | Failure to Identify and Deliver CIP | Cause: Operational pressures and historic under-delivery mean that inadequate CIP is identified and delivered on a recurrent basis in order to reduce the underlying deficit and a deliver the financial plan 2023/24<br><br>Effect: This could lead to reputational damage, regulatory intervention and hold ups around securing long term strategic capital and revenue funding such as digital and BBF | Catastrophic | Likely | 20 | 1)Recovery Group<br>2)Restructured Integrated Governance Group for care pathways<br>3)Finance, Performance & Digital Committee<br>4)System Transformation and Efficiency Committee / System Recovery Board<br>5)PMO team in place with Delivery Director leading<br>6)Regular business planning round table meetings<br>7)Budgetary control framework<br>8)External support from Deloitte on savings opportunities identification and delivery had been procured<br>9) Recovery Groupmeeting biweekly holding ISU to account<br>10)Planned CIP working group will be in place to support ISUs and corporate in identifying schemes to the Gap in delivery.<br>11) ICB level coordination is in progress<br>12) Delivery Director is now in post (Jan 2023) who will lead on embedding the Trust's single improvement plan | 1)Inadequate recurrent CIP identified for 2023/24<br>2)Inadequate progress on embedding the requirements of GIRFT<br>3)Slow progress on significant system wide savings solutions | 31/07/2023 | Catastrophic | Almost Certain | 25 | [26/05/2023 09:33:22 Dave Stacey] Updated DS May 2023<br>[30/01/2023 13:56:37 Tian Ze Hao] The 2022/23 CIP delivery gap is forecasted to be over £10m, in addition, within the delivered CIP in year, over £9m is non-recurrent. 2023/24 detailed CIP plan is still not in place. Delivery Director is now in post (Jan 2023) who will lead on embedding the Trust's single improvement plan<br>[12/09/2022 13:51:34 Tian Ze Hao] CIP delivery Board meeting biweekly holding ISU to account. Planned CIP working group will be in place to support ISUs and corporate in identifying schemes to close the Gap in delivery (currently at £16m+). In addition, ICB level coordination is in progress | Catastrophic | Possible | 15 | | | | | | |
| 1070 | 29/05/2014 | Corporate Level Risk | Emergency Services | Joann Hall | Lisa Houlihan | Chief Operating Officer | Performance Risk | Inpatient Nursing Adult (ACUTE) | HOS. Torbay Hospital ED (A&E) | Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard | Cause: Patient demand exceeding capacity within the ED department.<br><br>Effect: Failure of the 95% standard, poor patient experience and possible adverse clinical outcomes as patients not cared for in the correct environment.<br><br>Linked to other ED CLR:<br>DRM ID No 1095 Overcrowding In Emergency Department. | Catastrophic | Almost Certain | 25 | 1. Good data analysis available - ED dashboard linked with control room - good and accurate weekly data sheets produced to monitor performance.<br>2. New medical "O" drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier.<br>3. Escalation policy in place.<br>4. 3 x daily control meetings with real-time information and appropriate management responses.<br>5. Ward discharge coordinators have daily meetings to review ward discharges.<br>6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED.<br>7. "See & Treat" trial in 2017 was successful and is now used during periods of escalation.<br>8. JET Team now fully operational to provide support for early discharge.<br>9. Acute Care Model in Bay 5 to accept direct HCP referrals from 10th April 19. Prioritise use of EAU3 as assessment space, additional push from Jan 2020.<br>10. There are 3 improvement work streams in place with project plans for each; Emergency floor programme, ward processes, and Home First. We also have support from ECIST who are actively supporting a range of improvements. Governance structure in place to support these and currently looking to source additional project support.<br>11. Increased robustness of internal ED escalation.<br>12. Improvements to RAR space to enable additional capacity when unit is full.<br>13. Changes to corridor traffic to prevent thoroughfare use.<br>14. Creation of an Medical Receiving Unit in DSU as part of the COVID response.<br>15. Creation of a Surgical Receiving Unit on level 5 opening on 29/06/2020. | 1. Linkage of the overcrowding risk score not formally linked to the escalation policy. Need for better OPEL linked escalation.<br>2. Patient flow out of the ED and other assessment spaces (MRU/SRU) | 05/06/2023 | Catastrophic | Likely | 20 | [29/03/2023 11:27:49 Amanda Anders (Risk Officer)] Title changed by COO<br>[22/11/2022 17:30:40 Melody Andrews] Risk reviewed and no change at present<br>[10/06/2022 10:36:11 James Merrell] Risk reviewed and no changes at present. | Catastrophic | Unlikely | 10 | | | | | | |
| 2416 | 23/04/2019 | Corporate Level Risk | Torbay Pharmaceuticals | Emma Rooth | Emma Rooth | Deputy Chief Executive Officer - Dave Stacey | Financial Risk | Torbay Pharmaceuticals | Torbay Pharmaceuticals | Failure to Meet Financial Compliance with TP's 5 year plan (implemented April 2021) | Cause: Lack of clarity on national review - 18 months since Project Dartmoor paused. Assumptions in existing 5 year plan no longer viable.<br>Effect: Failure to meet financial targets. Significant financial, reputational and people risk. | Catastrophic | Almost Certain | 25 | 1. Annual budgeting process.<br>2. Five year plan with long term aims.<br>3. Monthly financial review and presentation at Torbay Pharmaceuticals Board meeting.<br>4. ERP implemented.<br>5. Standard costing model applied to all products in business.<br>6. Horizon scanning of new dosage forms, technologies and changes in clinical practice.<br>7. Development planning including licensing and product development.<br>8. Project and Resource planning. | 1. Ability of TP to make one-off investments (access to capital).<br>2. Post Brexit/Covid-19 impacts - inflation on labour and materials.<br>3. External investment. The entire plan was predicted on basis that significant external financing would be available.<br>4. Governance. Failure to separate from the Trust presents barriers in acquiring the skills and knowledge required to deliver on the plan.<br>5. Governance. The TP Board is not currently constructed to lead a global pharmaceutical business at high growth pace. | 31/10/2023 | Catastrophic | Likely | 20 | [28/04/2023 09:47:27 Kim Hodder] Action for Clear overseas targets and plan of action closed - Export Manager has clear sales targets.<br>[05/09/2022 14:06:22 Kim Hodder] Actions 10283 and 10287 closed.<br>Action 10282 progress updated.<br>Addition of Action 18722.<br>[05/07/2022 10:14:41 Amanda Anders (Risk Officer)] Risk discussed at July Risk Group. Agreed to add to CRR. | Major | Possible | 12 | Full implementation TP 5 year plan and ability of TP to make one-off investment. | Emma Rooth | 31/10/2023 | | | [05/09/2022 14:02:08 Kim Hodder] Unable to close gaps due to pause due to NHSE Review<br>[06/03/2020 12:03:39 Kim Hodder] TP Strategy Plan refreshed. Ongoing discussions with Trust. |
| 3486 | 14/11/2022 | Corporate Level Risk | All Departments | Liz Davenport | Liz Davenport | CEO (Liz Davenport) | Financial Risk | Administration | HOS. Torbay Hospital Hengrave House | Failure to Deliver Strategies that Supports the Delivery of System Priorities on Finance and Workforce | Cause: Failure to deliver strategies to support delivery of finance, performance, quality and workforce system priorities.<br>Effect: Insufficient financial resources to deliver adequate health and social care services to the population we serve.<br>Lack of skilled workforce to deliver future predicted demand and transformation.<br>Strategic partners do not deliver priority strategic programmes of work | Catastrophic | Likely | 20 | 1. Chair,CEO and Executive engagement with ICS Committess and decsion making groups<br>3.Development of ICS governance arrangements to include ICB, ICP Local Care Partnerships and Provider Collaboratives<br>4. ICS Board appointments, Executive Team and Programme Director capacity<br>5. Provider Collaboratives- Acute, MHLDN and plans for Primary Care and Community<br>6.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings.<br>7.TSDFT CEO leads the Acute Provider Collaborative and Chair, DCEO and CMO also members<br>8.Influence at Strategic/Clinical networks: ICS Executive, Finance Working Group and HRD Executive Forum<br>9.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events.<br>10. System Recovery Board.<br>11. Trust internal governance. | Internal<br>1.Lack of robust planning arrangements<br>2.Operational capacity and governance<br><br>External<br>3.Financial Plan/Devon System Health and Care Strategy<br>4.Lack of of engagement from partnership providers to impact positively on pace of change<br>5.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times.<br>6.Implications of revised governance arrangements on FT governance and decision making | 11/09/2023 | Catastrophic | Likely | 20 | [22/05/2023 10:04:29 Sophie Byrne] The following controls were added to the risk:<br>- System Recovery Board.<br>- Trust internal governance.<br>[14/02/2023 11:21:26 Amanda Anders (Risk Officer)] Discussed at risk group and approved onto the CRR<br>[09/02/2023 10:12:22 Sophie Byrne] The risk has been updated and an action plan added. | Catastrophic | Possible | 15 | Single Improvement Plan | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | System Operating Plan | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Trust Governance Process - Recovery Board | Liz Davenport | 22/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Leadership Capacity and Capability | Liz Davenport | 22/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Regain and Renew (SOF4 Exit plan) | Liz Davenport | 22/08/2023 | | | |

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Torbay and South Devon NHS Foundation Trust

| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description<br>Cause:<br><br>Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes<br>Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes<br>Last 3 entries minimum. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1697 | 07/11/2016 | Corporate Level Risk | Human Resources | Darran Armitage | Darran Armitage | Chief Peoples Officer | Financial Risk | Human Resources | Site Non-Specific | Difficulty In Recruiting Service Critical Staff And The Scheduling Of Staff (Workforce Risk). | Cause: Lack of strategic workforce planning means we are unable to proactively develop our workforce pipelines to satisfy our current and future workforce need. This is compounded by National shortages mainly due to the deficit between the numbers of trained staff required and the number coming through training providers.<br><br>Effect: Difficulties in delivering on corporate objectives and national targets. Increase in temporary workforce usage including agency leading to budget overspends.<br><br>Linked to Risks:<br>DRM 3209 CT Staffing Level (Workforce Risk)<br>DRM 3183 Inadequate Staffing Levels Creating Risk to Patient Safety and Potential to Impede Patient Flow (Workforce Risk)<br>DRM ID No 1432 - Histopathologist Staffing Levels Causing Operational Risk.<br>DRM ID No 1566 - Radiography Staffing Levels.<br>DRM ID No 1603 - Breast Radiology Team reduced availability - Vacancies in Main Radiology.<br>DRM ID No 1830 - Cancer Services Vacancy for Breast and Colo-rectal Clinical Oncology.<br>DRM ID No 1931 - Lack of Resource to Assist with IT Projects & Service Redesign.<br>DRM ID No 2066 - Vulnerability of Medical Take Due to Increases in Last 10 Years.<br>DRM ID No 2528 - Reduced Staffing Numbers Resulting In Inability To Keep Services Open.<br>DRM 1652 Vulnerability Of The Junior Doctors Rota In Medicine.<br>DRM 2928 Inadequate Medical Physics Resources Impacting on Service Provision<br>DRM 2528 Reduced Staffing Numbers Resulting In Inability To Keep Services Open (Workforce Risk).<br>DRM 2602 Recruitment and Retention of Staff. (TP) (Workforce Risk)<br>DRM 2576 Lack Of Anaesthetic Cover To Cover 85% Of Scheduled Lists.<br>DRM 3286 Physiology Workforce (Workforce Risk)<br>DRM 3231 Critical Staff Shortages in Radiotherapy Physics (workforce risk) | Major | Almost Certain | 20 | 1. Recruitment updates are reported to Board bi-monthly as part of Workforce Report.<br>2. Medical Recruitment is being looked at as part of the Trust's Recruitment Strategy working groups.<br>3. Performance Report identifies where compliance with RTT/ED/STC impacted by workforce shortage.<br>4. Nursing workforce strategy in place including capacity plan that identifies demand and supply routes (including overseas nursing, redesign and vocational career pathways) monitored by Workforce and OD group.<br>5. E-Rostering system in place for nursing staff.<br>6. Restricted use of agency staff.<br>7. Use of bank staff wherever possible.<br>8. Additional support from current staff.<br>9. Risk discussed at Local level with escalation process for risks.<br>10. 15+ being linked to this risk.<br>11. Risk discussed at HR SDU meetings. R+R Groups. Workforce OD Group, Quality & SDU Performance meeting, Nursing working board group meeting, Risk Group meeting, Executive Directors meeting, Audit committee meeting and Trust Board.<br>12. STP Workforce and Clinical network development.<br>13. Trust now part of ICS Retention Project for late stage career nurses and early stage career support to improve nursing retention. | Lack of strategic workforce planning capability and capacity.<br>Ctrl 2. Link between requirement to train additional staff and sufficient capacity to deliver placements for students and other trainees.<br>Ctrl 5. E-Rostering system not in place for all staffing groups. | 31/07/2023 | Major | Almost Certain | 20 | [03/05/2023 10:11:22 Amanda Anders (Risk Officer)] Risk review by CPO, score increased from 16 to 20 inline with linked risks.<br>[28/02/2023 15:34:01 Sarah Blacoe] emailed manager regarding update<br>[16/02/2023 10:42:23 Sarah Blacoe] emailed manager regarding update | Major | Possible | 12 | More effective utilisation of our temporary staff and developing our bank staff. | Judy Falcão | 31/10/2018 | Darran Armitage | 19/12/2018 | [19/12/2018 13:37:18 Sarah Blacoe] 19.12.18 Informed by Mike Mogford - Action completed<br>[31/08/2018 09:26:23 Sarah Blacoe] Bank arrangements on-going. No further progress re STP work.<br>[02/05/2018 12:22:56 Sarah Blacoe] Trust achieved NHSI cap for 17/18.<br>Bank arrangement in place for medical staff. Exploring with the STP opportunities for sharing bank workers.<br>[14/03/2018 11:16:37 Sarah Blacoe] Trust is under the NHSI Agency Cap. %rate for filling Nursing and HCA shifts.<br>[07/02/2018 15:06:03 Sarah Blacoe] Temporary Staffing Policy adopted. Trust is under the NHSI Agency Cap. %rate for filling Nursing and HCA shifts is currently 90%.<br>[01/12/2017 11:24:36 Sarah Blacoe] The Trust is currently under planned agency expenditure and is on target to achieve the NHSI cap by the end of the year.<br>[02/11/2017 14:02:49 Sarah Blacoe] Agency staff usage is under NHSI cap levels. Medical Staff Bank now set up. Trustwide Temporary Group meet regularly.<br>[31/08/2017 09:54:53 Sarah Blacoe] Use of Bank Staff, overtime and Premium Pay processes in place. Agency staff use has reduced to below the NHSI Agency Cap.(JV 31.8.17)<br>[11/07/2017 10:01:36 Sarah Blacoe] Successful Nurse Open Day held at the beginning of the year, with appointments made to the Bank and newly qualified staff.<br>[05/06/2017 14:01:46 Sarah Blacoe] Temporary Staffing Policy being developed.<br>[28/04/2017 15:48:14 Sarah Blacoe] Temporary Staffing Policy being developed. Draft policy to be presented to Trustwide Agency and Temporary Staffing Task Force at the end of July 2017 |
| 2412 | 23/04/2019 | Corporate Level Risk | Torbay Pharmaceuticals | Emma Rooth | Emma Rooth | Chief Finance Officer (David Stacey) | Financial Risk | Torbay Pharmaceuticals | Torbay Pharmaceuticals | Insufficient Access to Capital.(TP) | Cause: TP could be requested to reduce its capex budget in order to support the Trusts CDEL.<br><br>Effect: Inability to invest in items linked to Torbay Pharmaceuticals Strategic Plan and requirements by MHRA if capex is reduced. | Catastrophic | Likely | 20 | 1. Within year Capital plan in place.<br>2. Reviewed at TP Board meetings.<br>3. Meetings with Trust FD and TP Chairman.<br>4. Raised at Trust Board Meetings for assurance. | 1. Potential for change in financial requirements of the Trust/NHSE.<br>2. No long term capital budget visibility (>1 year) from NHSE for Trust/TP. | 31/10/2023 | Catastrophic | Likely | 20 | [28/04/2023 09:45:50 Kim Hodder] Following review no updates/changes to risk at this time.<br>[13/12/2022 11:01:29 Amanda Anders (Risk Officer)] Agreed at Risk Group to add to the CRR and Dave Stacey will be the Exec Lead<br>[24/11/2022 15:44:33 Amanda Anders (Risk Officer)] Email from Kim Hodder -I confirm following this afternoons TP Board Meeting changes to TP Risk Register have all been accepted | Catastrophic | Rare | 5 | | | | | | |
| 1815 | 05/08/2014 | Corporate Level Risk | Cancer Services | Alex Atkins | Ria McCoy | Chief Operating Officer | Performance Risk | Administration | Site Non-Specific | Non Compliance With The National Cancer Waiting Time Targets. | Causes: Insufficient capacity to manage demand across some cancer pathways.<br>A. LGI capacity for outpatient clinics, CT colon and colonoscop. Unable to deliver timed cancer pathways through diagnostics to enable achievement of the 62 day pathway consistently.<br>B. Urology capacity for outpatients and DSU diagnostics reduced. Need identified dedicated outpatient space to deliver diagnostics in outpatient setting (Prostate pathway) Significant delays to TP biopsies.<br>c. Consultant vacancies in Dermatology, Urology and Colorectal. Reliant on Locum cover.<br>D. Insufficient capacity in diagnostics - CT, CTC and colonoscopy to achieve the timed pathways for Lung, Urology and LGI.<br><br>Effects:<br>A. Clinical risk to patients with delays diagnosis and delayed access to treatments.<br>B. Increasing number of patients being reported as potential harm caused by delays to treatment.<br>C. Failing the CWT targets for 14 days referral to first seen. Increasing 62 day referral to treatment breaches.<br>E. Failing to achieve 28 day referral to diagnosis standard across many specialities<br>F. Additional work required to escalate, complete breach analysis and recovery plans.<br>G. Poor Trust reputation and increased scrutiny from regulators. | Major | Almost Certain | 20 | 1. Weekly Cancer Recovery Action Plan meetings with operational leads<br>2. Weekly Cancer Task and Recovery meetings with Senior Management and Devon ICB<br>3. Site specific escalation lists on Infoflex for operational managers to access<br>4. Cancer Clinical Leads meetings to share risks and concerns across the ICO<br>5. Regular reporting to ICO Risk & Assurance group to escalate risks and concerns<br>6. Cancer patients are always prioritised when capacity reduced | 1. Lack of Consultants to recruit to vacancies. (Substantive and locums.)<br>2. Clinical space and equipment to provide additional capacity<br>3. Lack of nursing staff in some areas to support additional clinical activity.<br>4. Significant increase in demand on services post COVID<br>5. Fully established CWT team against budget under resourced due to increasein demand and unable to track PTLs daily and escalation where appropriate | 30/06/2023 | Major | Almost Certain | 20 | [31/03/2023 16:22:48 Alex Atkins] Torbay remains in Tier 1 for cancer performance, with regular oversight from NHS E and Devon ICB. Whilst the over 62-day backlog is reduced, the current SOF4 and Tier 1 status' and regulatory scrutiny predicate that performance should remain as a significant organisational risk. To be reviewed in 3 months.<br>[14/11/2022 08:51:39 Jacqui Robinson] Significant increase in 2ww referrals, diagnostic capacity, appropriate outpatient space and staffing/vacancies across many services continue to impact on our ability to comply with National Cancer Targets. Main areas of concern continue to be Colorectal and Urology. Lack of appropriately skilled Data Analyst support is also impacting on Cancer Managers' time and causing delays for report request across all cancer sites. Outsourcing and insourcing being widely used across many sites in an attempt to reduce waiting times and overall PTL.<br>[28/06/2022 10:14:39 Jacqui Robinson] COVID, diagnostic capacity, appropriate outpatient space and staffing/vacancies across many services continue to significantly impacting our our ability to comply with National Cancer Targets. Main concerns remain in Urology and Colorectal due to the above. Lack of appropriately skilled Data Analyst support is currently having a huge impact on Cancer Managers' time and delaying reports being created and shared with various internal departments, the CCG or Cancer Alliance which is also a contributing factor to delays and our non-compliance with National uploads. | Major | Possible | 12 | review of new processes in multiple pathways to support the 28 day faster diagnosis standard. Update pathway and processes to ensure delays are reduced where clinically appropriate. | Jacqui Robinson | 12/06/2023 | | | [04/05/2023 09:07:56 Jacqui Robinson] The Trust continues to be in Tier 1 in relation to our cancer performance against national targets. Insourcing and outsourcing is ongoing and we are working closely with both the Cancer Alliance and CCG in relation to improving our pathways in line with NICE Best Practice Timed Pathways. Diagnostics delays are our main challenge at the beginning of our cancer pathways and impacting on our 28, 31 and 62 day pathways across most of our cancer sites.<br>[06/04/2023 14:02:57 Jacqui Robinson] The Trust continues to be in Tier 1 for our performance against national cancer targets but despite this we have seen a great improvement in our performance with both the 28 and 31 day targets being achieved |
| | | | | | | | | | | | | | | | | | | | | | | | | | The Urology service are an outlier across the Peninsula for template prostate biopsy service. Should be delivering as an outpatient procedure under LA, which will reduce delay to diagnosis and increase DSU capacity. An appropriate outpatient suite required to deliver a safe service at Torbay Hospital | Kevin Pirie | 08/07/2022 | | | [09/05/2022 12:23:38 Ali El-Eleimi] No change in status following the relocation of urology services to Paignton, still waiting an EXE decision on suitable space within OPD at the main site.<br>[05/05/2022 09:43:09 Jake Gibbons] Reassigned to Ali El-Eleimi from Neal Foster<br>[01/03/2022 11:03:36 Neal Foster] No decision yet on Elizabeth, escalated to executive, work was due to start April 22. In the meantime urology have been relocated to Paignton to clear space on L2 for MRU |
| | | | | | | | | | | | | | | | | | | | | | | | | | There a 10s of actions related to the achievement of this risk, these are need to be recorded in a central Trust's Cancer Action Plan and overseen through the Cancer Cabinet structure. | Alex Atkins | 31/03/2024 | | | [02/08/2022 08:20:39 Alex Atkins] Action plans in place for key sites - ongoing monitoring needed<br>[10/03/2022 14:43:51 Alex Atkins] Completed for Breast, Derm, Urology and LGI.<br>[25/02/2022 08:41:14 Alex Atkins] 25/02/2022 - Action plan template created and started to be populated<br>[14/12/2021 11:00:18 Alex Atkins] 14/12/2021 - Draft action plan in place |
| 1266 | 01/10/2015 | Corporate Level Risk | All Departments | Sandie Heyworth | Derren Westacott | Chief Operating Officer | Performance Risk | Administration | HOS: Torbay Hospital | Failure to Achieve Constitutional Target Regarding RTT Resulting in Poor Patient Experience And Quality Of Care. | Cause: Supply and demand imbalance across most specialities to meet constitutional waiting times, leading to an inability to deliver quality patient experience in relation to waiting times.<br><br>Effect: Poor patient experience and quality of care, reputational impact for the Trust<br><br>Linked to Risks:<br>DRM ID No 2307 - Oncology Outpatient Clinic Issues.<br>DRM ID No 2036 - Endocrine Outpatients - Increase on Demand with Limited Consultant Time. | Major | Almost Certain | 20 | 1. Performance reporting and action plans with support of the Performance team, via Risk and Assurance weekly meeting<br>2. Waiting list management process, weekly PTL meetings<br>3. Operational teams identifying capacity and maximising all available sessions, also utilising insourcing companies and outsourcing where able. ICB supporting and involved with oversight<br>4. Support from other specialties creating sense of team working, ie UGI team supporting colleagues within Colorectal to reduce cancer backlog. Greater system working across the region with Urology<br>5. regular monitoring of demand in services, use of Tableau now integral part of planning | 1. Saturday list until the end of the year - dependent on number of theatre and medical staff volunteering.<br>2. Insufficient training grades resulting in consultants having to action down.<br>3. Inability to outsource complex patients - patients are deconditioned and higher ASA levels reducing ability to transfer care<br>4. Funding considerations not supporting recruitment of consultant surgeons.<br>5. National shortage of urology consultants.<br>6. Unable to source anaesthetic locums.<br>7. Heat and humidity issues within theatres - ongoing concerns across both seasons (summer and winter) | 30/06/2023 | Major | Almost Certain | 20 | [25/05/2023 14:32:32 Derren Westacott] Achieved reduction in waiting time. No 104 week waits target to reduce waits to under 65 weeks by 31 March 2024<br>[17/01/2023 13:02:31 Amanda Anders (Risk Officer)] Risk re-written by Nicky Croxon to ensure it is completely up to date.<br>[27/09/2021 09:40:03 Neal Foster] Best week 29th Sept allowing Ella to be use for DSU recovery and ortho patients.<br>Response for OT limited at AfC and LNC rates<br>Approval sought for insourcing of urology diagnostics<br>Sessions at Tiverton and Ottery picked up for TP biopsies.<br>MSH transfers OP/DCIP continue as do 5 endoscopy sessions per week | Moderate | Likely | 12 | | | | | | |

**CRR June 23.xlsx**

Torbay and South Devon NHS Foundation Trust

| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description<br>Cause:<br><br>Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes<br>Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes<br>Last 3 entries minimum. |
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| 3030 | 12/03/2021 | Corporate Level Risk | Human Resources | Darran Armitage | Darran Armitage | Chief Peoples Officer | Operational Risk | Human Resources | Site Non-Specific | Staff Fatigue Impacting on Ability to Deliver Services (Workforce) | Cause: Staff fatigue following covid pandemic, annual leave not being taken due to operational pressure and covering additional shifts is leading to staff burnout. The requriement to improve performance to reduce long waiting lists will likley add mental load to individuals.<br>Effect: Increased level of sickness, long term sickness above normal levels, staff turnover, impact on uptake of annual leave, and a decrease in productivity and performance in staff that remain. | Major | Almost Certain | 20 | 1) Investment in health and wellbeing support including high level mental wellbeing.<br>2) A comprehensive package of health and wellbeing interventions, support and guidance with enhanced measures to be offered via management structures and self referral.<br>3) An analysis of supporting data on staff sickness, overtime, agency spend and unused annual leave to help identify services that may be vulnerable.<br>4) Trust leadership to use the data provided to control and mandate the pace and pressure of recovery in vulnerable services.<br>5) Expanding the number of Wellbeing Buddies across the Trust.<br>6)Continuing with bespoke listening sessions in particular for teams who are part of the system capacity and recovery plans.<br>7) roll out Apr 2023 of Regain and Renew plan provides clear priorities and permission to innovate/stop work to focus only on priorities.<br>8)Roll out of Leadership and Management framework Q2 2023 will enhance managers efficiency and improve staisfaction and reduce burnout.<br>9) Workforce Transformation programme, focusing on better roster management will improve identification of additional shifts and how they are managed with notice. | 1) Scarcity of specialist skills in some areas to fill vacancies, exacerbating problem.<br>2) Financial envelope available to aid recovery | 31/07/2023 | Major | Likely | 16 | [03/05/2023 12:01:50 Amanda Anders (Risk Officer)] (02/05/2023) by CPO: Risk cause and controls updated. Roll out of Regain and Renew engagement plan will help treat this risk, enabling people to understand the priorities, how to focus only on what is required, how to embrace new ideas to improve efficiency, and the roll out of leadership and management development will aid greater understanding of workforce management and pressures and how to better manage them. WIT data 2/5/23 reiterates update from 1/3/23 that remain red for 6 of 9 parameters, but with falling levels of sickness.<br>[01/03/2023 10:10:37 Sarah Blacoe] WIT produce fragility score as part of the ISU workforce information this looks at sickness; rolling sickness; long term sickness; age profile; Holiday taken; overtime; bank and agency and turnover – It highlights the cost centres that are red for 6 or more of the 9 parameters<br>[28/02/2023 15:33:16 Sarah Blacoe] emailed manager regarding update | Major | Possible | 12 | | | | | | |
| 1603 | 08/07/2016 | Corporate Level Risk | Breast Care | Sandie Heyworth | Derren Westacott | Chief Operating Officer | Performance Risk | Breast Care | Site Non-Specific | Diagnostic Demand and Capacity Constraints | Cause:<br>1. Insufficient Radiology capacity to meet demand<br>2. Increase in 2WW referrals<br>3. 4th Breast Radiologist has left - have appointed replacement but gap until September<br><br>Effect:<br>1. The whole Breast Service at risk of falling over without adequate Breast Radiology support and cannot provide a diagnostic service<br>2. Patients are experiencing a delay to their cancer diagnosis on a 2WW & 14 day symptomatic pathway as one-stop assessment not available for all appointments booked.<br>3. Surgical patients requiring wires may not be booked within 31/62 day target if radiology capacity is not available on planned date of surgery.<br>4. Breast screening film reading and assessment breaches.<br><br>Linked to Risk:<br>CLR DRM ID No 1697 - Difficulty in Recruiting Service Critical Staff. (16)" | Major | Almost Certain | 20 | 1. Micromanagement of radiology, radiography and surgical rotas to optimise the radiology capacity available.<br>2. Every radiological appointment, if patients cancel, is backfilled with either a symptomatic or screening patient where possible.<br>3.Advanced Practice Radiographer now trained and providing capacity in clinic<br>4. Additional reader now completed training<br>5. Additional sessions requested with Radiologists<br>6. Liaison with Radiology Ops Mgr for priority to be given to Breast if possible when timetables being planned<br>7. Breast radiology support via additional paid sessions for visiting consultants | 1. Referrals are unpredictable<br>2. The Radiologists may not want to / be able to do additional sessions.<br>3. Current PT Breast Advance Practice Radiographer has retired and returned and could leave at any time giving 3 months' notice.<br>4. Locum sessions are ad hoc | 31/07/2023 | Major | Likely | 16 | [05/06/2023 09:16:38 Sandie Heyworth] Cons Radiographer has been off sick for 2 weeks with a back problem - lost imaging capacity and locums cannot support any more than already<br>[19/04/2023 14:50:45 Sandie Heyworth] Updated cause and effect, controls and gaps. No change in scoring as risk remains at current levels.<br>[17/04/2023 08:04:53 Sandie Heyworth] Permanent radiologist has left, have appointed but not starting until September. Continue to use locum radiologists from within region on a sessional basis. Advanced Practice Radiographers (2) almost at completion of training. | Major | Unlikely | 8 | | | | | | |
| 3195 | 19/06/2021 | Corporate Level Risk | Torbay Pharmaceuticals | Leon Rudd | Emma Rooth | Managing Director Torbay Pharmaceuticals (Emma Rooth) | Financial Risk | Torbay Pharmaceuticals | Torbay Pharmaceuticals | NHS Elective Surgeries Impacting on Sales | Cause: Reduction in NHS elective surgeries due to Covid<br>Effect: Impact to sales | Major | Likely | 16 | Focusing on alternative business such as Exports and CMO Business | TP has no influence on Hospital Schedules | 31/10/2023 | Major | Likely | 16 | [28/04/2023 09:31:21 Kim Hodder] No changes to risk at this time.<br>[17/12/2021 09:20:07 Amanda Anders (Risk Officer)] Risk score increase validated at TP Board<br>[13/12/2021 10:43:21 Kim Hodder] Scoring updated to reflect financial impact. | Moderate | Possible | 9 | | | | | | |
| 3287 | 11/10/2021 | Corporate Level Risk | Stroke Team | James Hobbs | Shelly Machin | Chief Operating Officer | Clinical Safety Risk | Stroke Service | HOS: Torbay Hospital George Earle Ward | Stroke Services (overarching risk) | Cause:<br>1) Vulnerability of nursing workforce; high number of new nurses including overseas nurses filling what were previously high number of vacancies.<br>2) Challenge to ensure all clinical staff gain & maintain stroke competencies; high turnover & large number of new staff plus pressures in system on capacity to give & to receive training.<br>3) Significant pressure within the system including poor flow; challenges to get patients to the right ward within 4 hour target window<br>Effects:<br>1) & 2) a) Risk of increased clinical incidents; staff not able to get specialist skills in a timely manner.<br>b) Impact on staff health & wellbeing; experienced staff having to support less experienced staff & trying to train staff in an already pressured system<br>c) Difficulty covering specialist nurse & thrombolysis rotas<br>3) a) Performance on SSNAP - particularly Domain 2 time to & time spent on a stroke unit - poor & continuing to deteriorate<br>b) Reputational risk; Domain 2 is part of CQC performance metrics<br>This service sits within the category of small and vulnerable services which will only be fully addressed through networking on clinical services across the wider Devon footprint.<br>Linked risks:<br>1069 Stroke Service Performance Measured in SSNAP - Bed Occupancy and Direct Admission.<br>3150 Stroke Nursing: Skills & Capabilities (Workforce Risk) | Major | Likely | 16 | 1) Training programmes in place<br>2) & 3)& 4) ADNPP leading Health & wellbeing work across ISU to support all staff<br>5) a) stroke improvement plan in place detailing actions & supporting the monitoring of progress<br>b) Regular breach analysis & SSNAP meetings to monitor progress<br>c) Assurance that stroke outliers are seen by Stroke team | Control 3) Ongoing challenge to maintain skills<br>Control 5) b) Breaches continue; as few as 2% of patients reaching the stroke unit in 4-hours with consequential impact on ability to get specialist assessment within time, swallow screening etc.<br><br>NB: Stroke Risk 1069 remains scored at 16 due to inability to get sustained improvement on Domain 2 | 30/06/2023 | Major | Likely | 16 | [06/03/2023 16:23:55 Lesley Wade] Risk reviewed. Gap in control updated & action updated. Action owner changed.<br>[12/10/2022 13:50:35 Lesley Wade] Risk reviewed & updated. Linked to 1069 which has also been updated & retains same score. Actions reviewed & RO changed to James Hobbs.<br>[01/06/2022 09:36:18 James Hobbs] Risk description and controls updated to reflect that risk 1072 has now been closed.<br>Actions reviewed and updated. | Major | Unlikely | 8 | 1) Stroke improvement plan in place to monitor actions/improvements particularly in respect of staff training/competencies across all professions. Improvement plan monitored via Management meetings or when these are cancelled due to operational pressures via direct links to action holders | James Hobbs | 30/06/2023 | | | [06/03/2023 16:23:14 Lesley Wade] Plan has been refreshed & key actions clinical owned. Detail now being built into plan which is being monitored by Clinical Lead & Operational Manager<br>[11/01/2023 08:51:18 Lesley Wade] Ongoing. James Hobbs is refreshing the plan<br>[12/10/2022 13:48:58 Lesley Wade] Ongoing. Actions from Peer review being added to plan |

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Torbay and South Devon NHS Foundation Trust

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| 3437 | 09/08/2022 | Corporate Level Risk | Torbay Pharmaceuticals | AR3 | Emma Rooth | Deputy Chief Executive Officer - Dave Stacey | Operational Risk | Torbay Pharmaceuticals | Torbay Pharmaceuticals | HVAC Cooling Capacity Insufficient During Extreme Hot Weather | Cause: Extreme heat weather conditions.<br><br>Impact:<br>During extreme heat weather conditions, the temperatures in the GMP manufacturing and equipment preparation areas increase as the cooling capacity of the current air chillers is insufficient to maintain controlled conditions.<br>The consequence of the increasing room temperatures leads to risks to products and revenue.<br>Product risk 1 is caused by operators fully gowned in clean room clothing sweating which negates the barrier created by the clean room clothing and shedding skin in to the environment creating extra viable and non-viable particulates in to the area causing microbial and particulate risk to products and the environment.<br>Product risk 2 is caused as most products should be maintained at 20-25C and there is a risk the upper limit could be surpassed if extreme heat conditions persist creating deviations.<br>Financial risk is created from the possibility of failing batches being manufactured during extreme heat conditions or making the decision not to manufacture during such events. | Major | Likely | 16 | 1.Internal Chiller Units currently run at 100% capacity to maintain GMP manufacturing/prep rooms at 20-25C (regulatory requirement). | 1.There is no ability to increase current cooling capacity. | 31/10/2023 | Major | Likely | 16 | [28/04/2023 09:30:20 Kim Hodder] No updates/changes at this time<br>[05/01/2023 15:50:29 Kim Hodder] Review date amended to end of March 2023<br>[06/09/2022 11:32:03 Amanda Anders (Risk Officer)] Risk approved onto the CRR | Major | Possible | 12 | Evaluate and investigate the upgrade to existing chiller system for HVAC in GMP manufacturing and prep rooms | Alun Rees (Inactive User) | 31/10/2023 | | | |
| 3485 | 14/11/2022 | Corporate Level Risk | All Departments | Adel Jones | Liz Davenport | CEO (Liz Davenport) | Operational Risk | Administration | HOS. Torbay Hospital Hengrave House | Failure of ICS Operating Framework to Support Collaboration in Line with Health and Social Care Policy Requirements | Cause: Failure of the ICS to create operating framework to support collaboration.<br>Effect: Poorly defined shared vision and objectives and no strategic approach to issue of risk, costs and benefits<br>Failure to engage stakeholders Risk of sanctions due to lack of collaboration | Major | Likely | 16 | 1.CE and Executive engagement with PCSS and CE Leadership Groups.<br>2.Appropriate representation on ICS Board and key committees including NED appointments<br>3.ICS operating framework in place<br>4.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings.<br>5.CEO is the ICB Acute Provider Trust Representative<br>6.Influence at Strategic/Clinical networks: ICS Clinical Leadership Group, Urgent and Emergency Care Network, System Resilience Groups, A&E Delivery Boards.<br>7.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events. | Internal<br>1.Strengthening of planning arrangements<br>2.Realignment of capacity<br>External<br>3.Development of formal reporting process through system and organisational governance<br>4.Devon System Health and Care Strategy to be finalised<br>5.Limited to influence the direction of change in the local health economy<br>6.Lack of engagement from partnership providers to impact positively on pace of change<br>7.Lack of clarity on population outcomes, prevention plans and specific priorities for change defined within 'place-based plans' is limited.<br>8.Maturity of relationships and collaborative working arrangements<br>9.Implications of revised governance arrangements on FT governance and decision making | 30/06/2023 | Major | Likely | 16 | [30/05/2023 10:49:58 Amanda Anders (Risk Officer)] Reviewed by Adel Jones on 26/05/23<br>[14/02/2023 11:24:38 Amanda Anders (Risk Officer)] This risk was discussed at February Risk Group and approved onto the corporate risk register.<br>[09/02/2023 10:08:32 Sophie Byrne] Risk has been updated and an action plan has been added. | Major | Unlikely | 8 | Alignment of Trust activity in ICS operating framework | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Trust Strategy and Single Improvement Plan. | Liz Davenport | 09/08/2023 | | | |
| 3484 | 14/11/2022 | Corporate Level Risk | All Departments | Adel Jones | Liz Davenport | CEO (Liz Davenport) | Operational Risk | Administration | HOS. Torbay Hospital Hengrave House | Failure of Acute Provider Collaborative to Deliver on Acute Sustainability Plan Programme | Cause: Failure of the ICS to create the conditions for collaborative working and delivery of the shared goals in relation to the acute sustainability plan and community.<br>Effect: No improvement in acute services or outcomes for population served by the Trust.<br>Challenges arising from competing priorities from different partners. | Major | Likely | 16 | 1. All Boards signed up to Acute Provider Collaborative<br>2. Acute Sustainability programme in place with engagement from CEO, CMO, DTP and clinical teams<br>3. Workshops underway with outcomes reported to TMG<br>4. Fragile Services workstream in place led by DTP for the system<br>5. System Recovery Board for ICS with Execs reporting on key system workstreams | Internal<br>1.ICS governance frameworks are maturing and aligned with Trust Improvement Plan<br>2. TSD proposal to improve board oversight to BBF committee<br>3. SOF4 plan in place providing additional resource to deliver the strategic acute provider collaborative objectives | 30/06/2023 | Major | Likely | 16 | [30/05/2023 10:55:15 Amanda Anders (Risk Officer)] Reviewed by Adel Jones 26/05/23- Controls and gaps in control updated<br>[14/02/2023 11:25:40 Amanda Anders (Risk Officer)] This risk was discussed at February Risk Group and approved onto the corporate risk register.<br>[09/02/2023 09:59:56 Sophie Byrne] The risk has been reviewed and updated and a comprehensive action plan has been added. | Major | Unlikely | 8 | Develop the Peninsula Acute Provider Collaborative decision making framework. | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Peninsula Acute Sustainability Plan workshops in progress. | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Engagement in One Devon Strategy. | Liz Davenport | 09/08/2023 | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | Stakeholder management engagement. | Liz Davenport | 09/08/2023 | | | |
| 3316 | 12/11/2021 | Corporate Level Risk | All Departments | Sandi Clemo | Christopher Knights | Director of Transformation and Partnership (Adel Jones) | Financial Risk | Administration | Site Non-Specific | Failure to Complete the Outline Business Case for the NHP Programme (Overarching Risk) | Cause: The BBF team are not able to complete the Outline Business Case for the NHP programme in a timely manner<br>Effect: Risk in securing funding for the programme<br><br>Linked to the following risks:<br>3270 BFF Commissioning - Workforce Risk (closed)<br>3269 BFF- Business Case Authorship - OBC and FBC (closed)<br>3268 BFF- OBC and FBC Business Case Authorship -(CIP) (closed)<br>3267 BFF: OBC Support Services- Lack of Efficiencies (closed)<br>3266 BFF: OBC - Support Services Not Aligned (closed) | Major | Likely | 16 | 1) The BBF programme office are working through all the requirements of a OBC to ensure that they have the required resource in place to deliver the programme.<br>2) There is regular dialogue with the National Team and Trust Executive to ensure that the matter is being escalated. | 1) The national team are not currently able to confirm definitive timescales associated with the completion of the OBC, but the BBF team are in regular dialogue to ensure that the matter is being escalated. | 01/06/2023 | Major | Likely | 16 | [27/03/2023 14:07:20 Sandi Clemo] Risk reviewed, no updates required - rescheduled review date for 01/06/2023<br>[07/12/2021 10:52:13 Amanda Anders (Risk Officer)] Agreed to add to CRR | Major | Likely | 16 | | | | | | |
| 2966 | 30/11/2020 | Corporate Level Risk | Laboratory Medicine | Anthony Lowe | Ria McCoy | Chief Peoples Officer | Operational Risk | Administration | HOS. Torbay Hospital Pathology Labs | Overarching Recruitment Risk in Lab Medicine (Workforce Risk) | Cause: Lab Medicine has a number of very experienced senior members of staff. As these staff members near retirement age the services will struggle to recruit at the same level of expertise that the Trust current employ. Haematology and Histopathology have experienced issues. Microbiology are also now affected.<br><br>Effect: Without a strong staffing model in place across the services there will be numerous issues associated with this risk:<br>A. Potential delay in turnaround times<br>B. Missed RTT targets, including cancer waiting times resulting in fines<br>C. No time allowance for case reviews<br>D. Unable to meet UKAS Standards in Cellular Pathology<br>E. Reliance on locum cover<br>F. Significant service delivery challenge<br>G. Significant recruitment challenge<br>H. Covid testing placing microbiology under pressure<br>I. Potential for existing staff to relocate for a better work/life balance<br><br>Linked risks<br>2131: Consultant Microbiologist Workforce Under Pressure<br>2807: Additional Staffing Required to Maintain Service Delivery (Microbiology) | Major | Likely | 16 | 1) Reduce non-essential workloads where possible<br>2) Request staff to reschedule leave<br>3) Reduce routine quality activities<br>4) Offer overtime<br>5) Current Consultants covering additional workloads<br>6) Locum booked for shifts that can not be covered<br>7) Request support from SEND network<br>8) Consider Outsourcing | 1) No guarantee that shifts can be covered<br>2) Backlogs continue to increase<br>3) National shortage in these specific roles may result in recruitment being unsuccessful<br>4) Cover provided may not include some key elements of the role<br>5) Unsuitable workload demand on existing staff<br>6) Reluctance for extra shifts due to current taxation issue with pensions of senior medical staff. Some departments with SEND Trusts having their own issues.<br>7)Financial implications to outsourcing | 31/07/2023 | Major | Likely | 16 | [24/05/2023 11:26:44 Anthony Lowe] Head BMS of Histo has currently left. Job matching of JD completed, awaiting vacancy approval. Uncertainty around Histo build may impact on<br>Consultant Microbiologist will be retiring end of August 2023. will return as retire and return in short term but reduced hours. Locums etc being investigated.<br>Network has been approached with a mutual aid request for Microbiology clinical support. Other sites(e.g. RCHT) under pressure. Both Histo and Micro to be reviewed as fragile services. Not sure yet of remedial actions.<br>Biochemistry under sever operation pressure du to band 5/6 maternity leave/sickness impacting on 24/7 rota. Under review with ADO<br>[08/03/2023 14:43:47 Anthony Lowe] Process to recruit a new Histology manager has begun. Currently at job matching.<br>Risks of recruitment of senior staff is recognised by South 1 Network but any actions could be long term.<br>Unsure mutual aid is possible based on all the Trust positions.<br>[25/01/2023 10:22:04 Anthony Lowe] Histology manager will be leaving in March. Consultant Microbiologist intends to retire in 2023. Locum | Major | Unlikely | 8 | | | | | | |

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Torbay and South Devon NHS Foundation Trust

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| 2948 | 13/11/2020 | Corporate Level Risk | Emergency Services | Lisa Houlihan | Nicola McMinn | Chief Operating Officer | Clinical Safety Risk | A and E Majors | HOS. Torbay Hospital ED (A&E) | Delay in MH Patients Being Transferred to Appropriate Placement/Assessment Environment | Cause: Frequent Occurrence's where vulnerable patients are admitted to EAU awaiting Mental Health Beds, or remain in ED for extended periods of time for the same reason.<br><br>Effects:<br>A. Delays in transferring patients to appropriate units due to bed availability.<br>B. Poor patient experience.<br>C. Huge strain placed on these areas, often requiring extra staffing to support, adding stress/workload for teams. | Major | Likely | 16 | 1. Clinic room at the front of ED converted to provide further ligature free review area.<br>2. Regular escalation of any long wait patient but MH particular focus to escalate and reduce delay | 1. Staffing for appropriate supportive observation being worked through yet not formally agreed therefore whilst every effort will always be made to provide a 1:1 staffing not always available.<br>3. DPT to provide guidance on supportive 1:1 requirement.<br>4. Once ED works complete the MH suite will return to its normal function - complete<br>5. Once ED work complete on the clinic room this will also provide a safer assessment environment.-complete<br>6. Once points 4 and 5 are complete this will reduce the overall risk. | 31/08/2023 | Major | Likely | 16 | [10/06/2022 10:34:58 James Merrell] Risk reviewed and no changes .<br>[08/03/2022 15:16:28 James Merrell] No new changes to the risk.<br>[03/12/2021 09:48:40 James Merrell] No changes to the risk | Major | Possible | 12 | | | | | | |
| 2957 | 19/11/2020 | Corporate Level Risk | Radiology and Imaging | Nick Rowles | Kevin Pirie | Chief Nurse (Deborah Kelly) | Health and Safety Risk | Radiology | HOS. Torbay Hospital Radiology West | Radiation Safety (Staff/Public) : Inadequate Management Controls (Regulatory Compliance) | THIS IS A TRUST WIDE ISSUE AND NOT SPECIFIC TO PAIGNTON & BRIXHAM ISU OR RADIOLOGY.<br><br>RADIOLOGY HAS BEEN SELECTED AS THE LOCATION SIMPLY AS IT IS THE LARGEST USER OF IONISING RADIATIONS<br><br>Cause: A significant number of inadequate controls regarding management of radiation safety (Ionising Radiations Regulations 2017-IRR17) have been identified.<br><br>Effect: These issues affect day to day safety of work with Ionising Radiations and are considered non-compliant with the requirements of IRR17 . Enforcement action in a number of areas is considered highly likely in the event of any inspection by HSE. There is evidence of a poor radiation safety culture in the organisation.<br>Linked risk:<br>2928: Inadequate Medical Physics Resources Impacting on Service Provision (workforce risk) | Major | Likely | 16 | 1) Radiation Safety Committee<br>2) Policies / Procedures / Systems for safe work | 1) There are widespread gaps in controls across the organisation.<br>2) Lack of or inadequate radiation risk assessments<br>3) Lack of effective process and control of Occupational Dosimetry<br>4) Inadequate training in radiation safety - lack of mandatory training<br>5) Inadequate Local Rules<br>6) Local Rules not followed by Staff<br>7) Lack of Radiation Protection Supervisors for Controlled Areas<br>8) In adequate numbers of Radiation Protection Supervisors<br>9) Lack of process of Cooperation between Employers / Outside Workers<br>10) Inadequate contamination monitoring in Nuclear Medicine<br>11) Lack of programme for assessment and monitoring of Radon in the workplace<br>12) Poor overall management of radiation safety | 20/06/2023 | Major | Likely | 16 | [06/04/2023 11:14:58 Nick Rowles] I have reviewed this risk today. Whilst there have been improvements in radiation safety and compliance, there are still significant gaps. Risk assessment in key areas of Nuclear Medicine and Radiotherapy are being drafted and identify actions required to improve safety and complaince. These actions will require implementation through Local Rues (instructions for safe work) on completion of the risk assessments. There is still no suitable and sufficient risk assessment in place for cardiac catheter laboraties and there are a number of indicators of concern regarding radiation safety and culture arising in this area. There remain other gaps in risk assessments.<br>In terms of Nuclear Medicine (ref external review), there has been progress around management of radioactive waste, and additional staff in Clinical Nuclear Medicine. Recruitment into the senior medical physics role at 8B however remains challenging and the position remains unfilled after 4 adverts. An alternative solution is being investigated.<br>Actions around this risk warrant review and updating<br>Whilst there has been some progress I feel the overall risk rating should remain unchanged<br>[18/11/2022 13:37:38 Tim Simpson] Action plan reviewed, position agreed. Still outstanding actions that are limited by lack of resource and inability to recruit to posts in Med Phys<br>[13/10/2022 13:26:34 Tim Simpson] Action updated, action plan to be reviewed with RPA | Major | Rare | 4 | To formally review this risk following the Radiation Safety Committee Meeting on 10/2/22. | Tim Simpson | 20/06/2023 | | | [17/05/2023 16:03:05 Tim Simpson] Have been unable to review with RPA who has no retired. New starter in June 2023, will review radiology aspects with her at that time<br>[28/02/2023 12:23:34 Tim Simpson] RSC on 6th March<br>[13/10/2022 13:26:02 Tim Simpson] Action plan fromulated and track on MS Teams. To review with RPA before month end |
| 2878 | 25/08/2020 | Corporate Level Risk | Estates | Paul Morgan | Jake O'Donovan | Chief Finance Officer (David Stacey) | Performance Risk | Estates Dvpt | HOS. Torbay Hospital Tower Block | Increased Fire Risk in the Torbay Hospital Tower Block due to Sustained Failure to Meet Statutory Standards | Cause: Due to the age, modifications made and use of the Torbay Hospital tower block it does not meet current statutory fire building standards.<br><br>Effect:<br>1. The lift lobby is no longer a sterile location which increases the potential fire risk in this area<br>2. The current primary evacuation stairwell route is compromised by the fire service attendance leading to a delayed evacuation of staff and patients<br>3. Death or injury leading to substantial financial penalties.<br>4. Non compliance with HTM 05-02 and PAS7 leading to an evacuation risk failure and/or inability for the fire service and ambulance service to mount an effective response | Catastrophic | Almost Certain | 25 | 1. L1 detection through the site<br>2. Fire risk assessments annually assessed<br>3. Fire wardens and clinical evacuation leads in place<br>4. 100k capital funding to be targeted in this area for remedial solutions<br>5. Annual exercise scheduled<br>6. Regular engagement with the fire service on this risk<br>7. Fire strategy in place and published<br>8. Fire training in place for staff.<br>9. Fire service engaged with and to attend site for planning and liaising on planning.<br>10. Security officers attending site three times a shift.<br>11. SSEP team has made contact with each department lead. | 1. No firemans lift to support evacuation.<br>2. No sprinklers to support evacuation.<br>3. Not enough evacuation equipment to mount and effective evacuation.<br>4. No third set of evacuation stairwell.<br>5. Lack of evacuation strategy in relation to the current secondary evacuation stair well.<br>6. Regular fire drills.<br>7. Store rooms and offices outside of the main compartment in the lift/escape route.<br>8. Inpatients housed in the tower block. | 31/05/2023 | Catastrophic | Possible | 15 | [05/04/2023 13:02:42 Paul Hayman] Sub station 1 Transformer works now due to complete in April 23 due to delays to accommodate Clinical activity.<br>Lift Motor room work is in progress and due to complete in April 23.<br>IT cabinets Fire Suppression systems to be installed in April 23.<br>[22/03/2023 14:37:03 Amanda Anders (Risk Officer)] Score reduced by Jake O'Donovan from 25 to 15 due to Fire remedials project now completed, bed store stood up so as to reduce clutter and corridor risk, all FRSAs now up to date.<br>[01/03/2023 15:29:53 Paul Hayman] Transformer upgrade due to be completed on 19th March. IT cabinets in 'protected lift lobby' fire suppression systems not connected at present.<br>Confirmation of progress for fire door works within Tower, 3 doors remaining and are scheduled to be replaced by the end of February, from Capital Development team. | Catastrophic | Unlikely | 10 | Please can you liaise with the fire service in order to arrange a live exercise on this area as part of the exercise strategy | Neil Faulkner | 01/08/2023 | | | [08/06/2023 08:19:04 Kevin Wood] Re assigned to Neil Faulkner the Trust Fire Safety Adviser<br>[10/02/2023 08:25:03 Kevin Wood] Neil Faulkner is taking this forward as the new Fire Advisor<br>[13/10/2022 14:59:19 Kevin Wood] Following the H&S committee meeting held on the 12.10.2022 it was agread that the excercise was to be put on hold untill the spring of 2023, taking into account the current status of Covid, the alterations being carried out in the tower and staffing levels, DSFRS informed and updated |
| | | | | | | | | | | | | | | | | | | | | | | | | | Review status of Fire Detection systems in Tower Block and conduct gap analysis of requirements. | Paul Morgan | 30/04/2023 | | | [22/03/2023 15:44:02 Paul Morgan] New fire doors and compartments have been installed.<br>Suppression systems within IT cabinets are in position but not connected or commissioned.<br>Second electrical supply works is in progress with the installation of the larger capacity transformer.<br>Programme has been delayed, now due to be completed in April 2023.<br>[04/07/2022 11:15:54 Rae Callcut] action passed to Paul Morgan due to reorganisation of teams and responsibilities<br>[03/11/2021 13:31:05 Paul Hayman] Tower Block works in progress. |
| | | | | | | | | | | | | | | | | | | | | | | | | | Carry out above-ceiling risk assessments in the Tower Block. | Ian Hackney | 20/01/2023 | | | [07/02/2023 08:49:25 Ian Hackney] This is an extensive piece of work and will require funding. Scope and specification document sent to Paul Morgan.<br>[07/12/2022 11:21:15 Paul Hayman] Ian requested to report findings of Fire Compartmentation to Risk Owner (Paul Morgan).<br>[04/07/2022 10:18:23 Rae Callcut] Building fabric has been tasked to carry out review of fire compartmentation across the site and will include above ceiling review of compartmentation. |
| 2920 | 12/10/2020 | Corporate Level Risk | Finance | Neil David Elliott | Dave Stacey | Director of Transformation and Partnership (Adel Jones) | Performance Risk | Finance | HQ. Regents House | Activity Dataset Non-Compliance For Community Setting | Cause: Non compliance in recording activity within the community setting.<br><br>Effect: Not able to report Activity on SUS, National Cost collection returns, Non compliant with Mandatory NHSE&I requirements. Unable to understand the activity and productivity within the community setting | Catastrophic | Possible | 15 | 1. A Community Data Development Steering Group has been formed that is Chaired by the CFO and will report to CASCIT.<br>2. The Head of Data Engineering is aiming to get 2 band 6 members of staff recruited to help with resource issues in the team, hopefully some of this resource can be directed to mitigating this risk.<br>3. In the meantime funding has been agreed for 60 days of agency staff to come in and start work on formulating the dataset. The plan is for this resource to start on Monday 4th October 2021. | No plan to implement the requirements during the role out of the trust wide community system. | 30/06/2023 | Catastrophic | Possible | 15 | [03/04/2023 14:24:27 Neil David Elliott] The agency resource that has been submitting our dataset will no longer be available from the end of April 2023. The submission task will be handed to the Data Engineering team, a handover is in progress. With regard to the PARIS system, John Broom is arranging discussions with clinical leads in April 2023 about system changes required to gather the necessary data.<br>[07/12/2022 14:11:49 Neil David Elliott] There has been no change to this risk since February 2022. The organisation is still using agency staff to submit the data that we are able to extract from our systems. We are not able to submit PARIS data until a system upgrade and re-design is achieved. Current estimate is that 60-70% of the data that should form part of this dataset is being submitted.<br>[18/05/2022 10:10:09 Neil David Elliott] The risk score has been reviewed by CASCIT and agreed that Performance risk would score 3 (Moderate - failure to meet national standards) and the likelihood would remain at 5 as the PARIS data would not be able to be included until the system changes had occurred. A score of 15 overall. | Catastrophic | Rare | 5 | The issue has been raised in reports sent to FDG and Board over many years, and raised again in the NCC report submission in October 2020 | Neil David Elliott | 30/06/2023 | | | [04/04/2023 07:52:07 Neil David Elliott] The agency resource that has been submitting our dataset will no longer be available from the end of April 2023. The submission task will be handed to the Data Engineering team, a handover is in progress. With regard to the PARIS system, John Broom is arranging discussions with clinical leads in April 2023 about system changes required to gather the necessary data.<br>[18/08/2022 15:22:49 Neil David Elliott] This situation has not changed since the last updated in February. An external agency resource is still employed to submit CSDS data from the systems that are able to comply. The PARIS system is still not able to meet the requirements and will not be for some years to come.<br>[16/02/2022 11:23:53 Neil David Elliott] Following the recruitment of external agency resource the Trust had been able to make partial CSDS submissions in the last 3 months. Data is being extracted and processed from 4 of our 5 Community IT systems. We are not able to submit data from PARIS, a system redesign is required to enable that. A project is underway to do this. It is estimated that 60% to 70% of the appropriate data is now being submitted. |

**CRR June 23.xlsx**

Torbay and South Devon NHS Foundation Trust

| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description Cause: Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes Last 3 entries minimum. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2965 | 30/11/2020 | Corporate Level Risk | Obstetrics | Jonathan Hindley | Joanna Bassett | Chief Operating Officer | Clinical Safety Risk | Obstetrics | HOS. Torbay Hospital Delivery Suite | Access to an Emergency Theatre for Obstetric Cases | Cause:<br>Due to the nature of obstetrics, urgent access to an emergency theatre is needed. During the planned upgrade to theatres there have been occurrences where treatment has been delayed due to lack of availability of access to an emergency theatre.<br>Effect:<br>1) Inability to provide care within nationally recommended timescales, eg Category 1 LSCS within 30 mins.<br>2) Potential delays may result in life threatening harm to a mother. or a baby | Catastrophic | Possible | 15 | 1) Daily morning safety huddle involving obstetrics, anaesthetics and theatre, to include which theatres are available, which lists could be 'crashed'<br>2) Review of position at each handover<br>3) Monday and Thursday - Theatre 10 (Griffin Suite) available | 1) Still potential that we are unable to go straight to theatre if clinically indicated. | 26/07/2023 | Catastrophic | Possible | 15 | [26/05/2023 11:21:14 Claire Jones] Progress delayed due to difficulties in recruiting ODP's both locally and nationally. Awaiting update from theatres regarding workforce planning.<br>[22/03/2023 10:30:05 Anne-Marie Whiting] Maternity Services have had no update on the thatre provision. Gwen Hotine to email Derren Westacott to get an update on the progress.<br>[23/11/2022 10:41:26 Claire Jones] Consultation process ongoing for theatre staff. Awaiting outcome early Jan. | Catastrophic | Rare | 5 | | | | | | |
| 2718 | 03/02/2020 | Corporate Level Risk | Estates | Helen Elkington | Jake O'Donovan | Chief Finance Officer (David Stacey) | Operational Risk | Estates Dvpt | Site Non-Specific | Inability To Expand Clinical Services Due To Lack Of Space. | Cause: The Torbay Hospital buildings are too cramped to accommodate further expansion of clinical activity in key areas, the Emergency Department, Radiology, Emergency Department, Outpatients Oncology etc.<br>Effects:<br>A. Inability to respond in a timely manner to emerging Pandemic Threats such as Covid-19, where a need to provide enhanced Red and Green pathways results in having to shut down key diagnostic or elective services<br>B. Inability to provide adequate social distancing within the existing buildings footprint.<br>C. Inability to bid for new clinical contracts or additional services.<br>D. Poor expansion opportunities and significant time pressures involved in any modifications.<br>E. Poor patient experience due to cramped and overcrowded conditions.<br>F. Waiting times increasing and targets not met.<br><br>Linked to-<br>DRM ID 2234: MDSS Medical Devices Library (MDL), Insufficient Space to Meet ICO's Expectations.(15)<br>DRM ID 1083: Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care.<br>DRM ID 2913: Lack of Space Due to Social Distancing/AGP<br>DRM ID 2975: Lack of Provision of IP Pre Assessment<br>DRM ID 3056: Increase UTC Activity Due to COVID Restrictions Lifting Resulting in an Increase in Holiday Makers<br>DRM ID 3207: Appropriate Procedure Room for Vascular Access in Patients and Complex Patients | Moderate | Almost Certain | 15 | 1. Covid Recovery Cell Reviewing opportunities to re-house services off-site to free up acute site capacity.<br>2. Cross-ISU group in place to review business cases to ensure space consequences are considered as part of future planning.<br>3. HIP2 seed funding received to scope Strategic Outline Case for new hospital development.<br>4. Space Group reformed and led by Director of Environment to prioritise strategic requirements across Trust sites. | 1. Limited controls possible.<br>2. Need to manage hospital within current space envelope for next 10 years. | 30/06/2023 | Moderate | Almost Certain | 15 | [17/01/2023 14:27:39 Paul Hayman] No Change - review in June 2022<br>[11/08/2022 13:08:12 Paul Hayman] No Change - review in October 2022.<br>[07/02/2022 15:24:43 Paul Hayman] Building a Brighter Future Outline Business Case not expected before October 2022. | Moderate | Unlikely | 6 | | | | Helen Elkington | | |
| 3293 | 14/10/2021 | Corporate Level Risk | Torbay Pharmaceuticals | David Houghton | Emma Rooth | Deputy Chief Executive Officer - Dave Stacey | Financial Risk | Torbay Pharmaceuticals | Torbay Pharmaceuticals | ITH Pharma- Loss of Future Revenues | Cause: Risk of loss of future revenues as a result of insolvency.<br><br>Effect: ITH Pharma has been charged with seven counts of supplying a medicinal product which was not of the nature or quality specified in the prescription on 27 May 2014. If the courts find against ITH, there are likely to be substantial fines and penalties which may affect the ability to continue trading. | Catastrophic | Possible | 15 | 1. No controls possible - external factor.<br>2. TP monitor progress of court case, along with updates from their credit insurance provider. | 1. No controls possible - external factor. | 31/10/2023 | Catastrophic | Possible | 15 | [28/04/2023 09:20:55 Kim Hodder] Following review no changes/updates and continue to monitor<br>[05/09/2022 10:04:29 Kim Hodder] TP continues to monitor ITH.<br>[25/02/2022 15:08:49 Kim Hodder] Dave Houghton has spoken with Andrew Winstanley (Sales Director) at ITH Pharma.<br>Andrew advised that ITH Pharma have had the full support of their bankers and insurers since the incidents in May 2014, and no restrictions have been placed on them (including the MHRA). He is going to share with Dave a redacted letter between ITH and their bankers that should provide some reassurance of this position.<br>The directors of ITH Pharma do not envisage any impact on day-to-day trading of the company, despite the admissions of guilt in relation to the Crown Court case. (1 x Insufficient risk assessment in place and 2 x supplying medicinal products not of nature or quality specified in the prescription). They have had almost 8 years of continued trade with the NHS since 2014 with no repeat issues and their business has continued to grow.<br>The directors are also advised that, should any civil claims arise in the future (and they are expecting them), their insurers will continue to defend their position and, if these cases are found against them | Catastrophic | Possible | 15 | | | | | | |
| 3372 | 26/04/2022 | Corporate Level Risk | Head and Neck (Including Dentistry) | MB2 | Derren Westacott | Chief Operating Officer | Clinical Safety Risk | ENT and Plastic Surgery | HOS. Torbay Hospital Outpatients Department | Potential Harm to Patients Due to Long Waits (Workforce Risk) | Cause: One Clinician currently on LTS (Head & Neck) and One clinician currently on Mat Leave, plus another surgeon leaving May/June 2023<br>Effect: loss of clinical activity in ENT in emergency cover, Head & Neck cancer speciality and General ENT | Major | Almost Certain | 20 | 1.Remaining Head & Neck Consultant has picked up additional work plus other ENT clinicians are covering where possible and have moved to 1:4 on call rota<br>2. Using a Consultant from RDUH to cover some sessions approx 2 per month as locum<br>3. Using insourcing/outsourcing company to provide additional resiliance to reduce backlog in service and assist with 2ww<br>Please see details below of previous Mutual Aid request and details of the agreement by RDUH.<br>Royal Devon University Healthcare NHS Foundation Trust will provide mutual aid with ENT surgical Head and Neck (H&N) services to Torbay and South Devon NHS Trust in response to this request in the short term (expected until 13th June 2022) in the following ways:<br>•Royal Devon will provide consultant telephone advice Monday – Friday on managing specific 2ww ENT patients.<br>•Royal Devon will oversee the management of all new H&N cancers diagnosed at Torbay for the period of the agreement. The majority of this activity will happen at Torbay (delivered by Royal Devon consultants as additional to job plan) wherever possible, but some patient care (inpatient and day case) will need to be transferred to Exeter (see below). Diagnostic scans and outpatient biopsies for these patients will happen at Torbay.<br>•Diagnostic and treatment surgery for ENT H&N patients will be undertaken in Exeter where this cannot be accommodated at Torbay. Torbay will provide theatre time to Royal Devon | 1. No capacity to cover sickness and to cover A/L<br>2. Risk of burnout from over works<br>3. Not sustainable Consultant cover from Locum Consultant<br>4. Inability to recruit further staffing | 03/07/2023 | Major | Possible | 12 | [24/05/2023 14:04:30 Derren Westacott] Amended risk description to describe the risk rather than the issue. Mitigation is lowering the risk however more needs to be done to build a resilient team and recruit to vacancies.<br>[19/12/2022 14:39:02 Mandi Burroughs] To review stand alone post in new year - Meeting 06/01/2023, to gain agreement for additional shared post from August 2024. Financial agreement has been given.<br>[17/11/2022 16:54:15 Mandi Burroughs] Further post ENT stand alone advertised - has closed 16/11/2022 - no suitable applicants. CSL meeting with MD 21/11/2022 to discuss furher mutual aid request for support for Head & Neck Cancer Service | Major | Rare | 4 | | | 17/06/2022 | | | |

CRR June 23.xlsx

Torbay and South Devon NHS Foundation Trust

| ID | First Recorded. | Type | Department | Risk Owner | Risk Owners Senior Mgr | Risk Owners Director | Risk Category | Speciality | Risk Location | Title | Description<br>Cause:<br><br>Effect: | Consequence (Inherent / Initial) | Likelihood (Inherent / Initial) | Rating (Inherent / Initial) | Controls in place | Gaps in Control | Review due date | Consequence (Current) | Likelihood (Current) | Rating (Current) | Risk Progress Notes<br>Last 3 entries minimum. | Consequence (Residual) | Likelihood (Residual) | Rating (Residual) | Synopsis of Open Action Point/Plan | Action Point Owner | Review due date (Action Plan) | Completed by | Completed on | Action Plan Progress Notes<br>Last 3 entries minimum. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | surgeons on site at Torbay during already planned additional sessions on Tuesdays, to prevent the patients travelling and to reduce the demand on Royal Devon theatre time but this may not be possible for all cases. The OMFS team in Torbay will take over cases from Torbay ENT where this is appropriate due to cross-over between specialties, ie: thyroid and some neck dissections, rather than these being transferred to the Exeter ENT team. The general ENT team in Torbay will cancel less urgent surgery to undertake H&N surgery at Torbay that is within their scope of practice/capability, eg: tonsillectomy, panendoscopy (where patient not a candidate for radical surgery), microlaryngoscopy, lymph node biopsies.<br>•Torbay patients requiring oncological treatment for their H&N cancer will be treated in Torbay.<br>•The histopathology for all surgery done in Exeter on Torbay patients will be transferred to Torbay for analysis.<br>•All relevant scans and notes for Torbay patients having surgery in Exeter need to be made available on Epic in advance of the day of surgery.<br>•Royal Devon surgeons will undertake complex surgical treatments in Exeter – these patients would normally have been treated in Exeter but by a Torbay surgeon. There are already dedicated theatre lists in Exeter for the Torbay surgeons so these will be covered where possible by the Royal Devon consultant team as extra to job plan. This locum cost will be paid for by Royal Devon.<br>•Follow-up H&N clinics in Torbay will be provided by Royal | | | | | | | | | | | | | | | | |
| 3200 | 01/07/2021 | Corporate Level Risk | Paediatrics (Child Health) | Stephen Holman | Shelly Machin | Chief Operating Officer | Clinical Safety Risk | Paediatrics | HOS. Torbay Hospital Outpatients Department | Demand Exceeding Capacity Within The Paediatric Eating Disorder Pathway | Cause: The paediatric team have experienced a 400% increase in referrals over the last year.<br><br>Effect: This has had a significant impact on both nursing staff and medical staff capacity to provide a comprehensive service which is resulting in an increase of acute/complex and pervasive presentations resulting in long or repeated hospital admissions. | Moderate | Almost Certain | 15 | 1. Cases are prioritised and risk assessed<br>2. Additional clinic established once a week to review urgent patients for admission avoidance<br>3. Weekly ward rounds to review patients<br>4. Dietetic professional lead weekly review of patients | 1. Limited Nursing and medical capacity to provide service | 09/06/2023 | Moderate | Likely | 12 | [12/05/2023 08:22:58 Natalie Tidball] This risk is currently under review. It does not reflect the current situation and therefore it is being re-written to fully depict current pressures. Scoring has been reduced in the meantime.<br>[19/01/2023 13:56:53 Natalie Tidball] Demand unchanged. Discussed with ED leads and risk to remain as it is. Discussed monthly with wider Child Health team at Senate. Review date changed<br>[17/10/2022 15:48:34 Rebecca Hudson] Review date extended to end of Month.<br>Risk due to be reviewed by the Child Health team and was flagged at governance meeting on 12/10 that this needs a thorough review to assess if risk remains and narrative is unchanged as it has been on the register for over 1 year.<br>Risk handler changed to N Tidball - interim CGC | Moderate | Unlikely | 6 | This risk is out of date and does not accurately reflect current pressures. Action to Review and redefine risk with mitigations and action plan in collaboration with CAMHS and dietetics. | April Hopkins | 02/06/2023 | | | |

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| **Report to the Trust Board of Directors** | | | |
|---|---|---|---|
| **Report title**: SID Role Description | | | **Meeting date**: 28th June 2023 |
| **Report appendix** | Senior Independent Director ("SID") Role Description | | |
| **Report sponsor** | Director of Corporate Governance and Trust Secretary | | |
| **Report author** | Corporate Governance Manager | | |
| **Report provenance** | Governor Nominations and Remuneration Committee – 30th May 2023 | | |
| **Purpose of the report and key issues for consideration/decision** | In line with best practice a role description has been prepared to provide clarity to the role of the SID.<br><br>The role description was considered at a Governor Nominations and Remuneration Committee on the 30th May 2023 and the Committee is recommending approval of the document by both the Board of Directors and Council of Governors.<br><br>The Board is asked to consider and approve the SID role description, noting it will also be presented to the Council of Governors for approval at its meeting to be held on the 2nd August 2023. | | |
| **Action required (choose 1 only)** | **For information** ☐ | **To receive and note** ☐ | **To approve** ☒ |
| **Recommendation** | The Board of Directors is asked to approve the SID role description. | | |

**Summary of key elements**

**Strategic goals supported by this report**

| **Excellent population health and wellbeing** | | **Excellent experience and providing care** | |
|---|---|---|---|
| **Excellent value and sustainability** | 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** | | **Terms of Authorisation** | |
|---|---|---|---|
| **NHS England** | | **Legislation** | |
| **National policy/guidance** | | | |

**Senior Independent Director Role Description**

*Taken from NHS Providers "The Foundations of Good Governance: A Compendium of Good Practice"*

In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary.

The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate.

Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.

Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.

In addition to the duties described here the senior independent director has the same duties as the other non-executive directors.

## The Senior Independent Director, the Chair and Non-Executive Directors

The senior independent director has a key role in supporting the chair in leading the board of directors and acting as a sounding board and source of advice for the chair. The senior independent director also has a role in supporting the chair as chair of the council of governors.

The senior independent director should hold a meeting with the other non-executive directors in the absence of the chair at least annually as part of the appraisal process.

There may be other circumstances where such meetings are appropriate. Examples might include the appointment or re-appointment process for the chair, where governors have expressed concern regarding the chair or when the board is experiencing a period of stress as described below.

## The Senior Independent Director and the Council of Governors

While the council of governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on their behalf as set out as best practice in the code of governance.

The senior independent director might also take responsibility for an orderly succession process for the chair role where a reappointment or a new appointment is necessary.

February 2023 V1.0

The senior independent director should maintain regular contact with the council of governors and attend meetings of the council of governors to obtain a clear understanding of governors' views on the key strategic and performance issues facing the foundation trust.

The senior independent director should also be available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

In rare cases where there are concerns about the performance of the chair, the senior independent director should provide support and guidance to the council of governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action.

Where the foundation trust has appointed a lead governor the senior independent director should liaise with the lead governor in such circumstances.

**The Senior Independent Director and the Board**

In circumstances where the board is undergoing a period of stress the senior independent director has a vital role in intervening to resolve issues of concern.

These might include unresolved concerns on the part of the council of governors regarding the chair's performance; where the relationship between the chair and chief executive is either too close or not sufficiently harmonious; where the trust's strategy is not supported by the whole board; where key decisions are being made without reference to the board or where succession planning is being ignored.

In the circumstances outlined above the senior independent director will work with the chair, other directors and/or governors, to resolve significant issues.

Boards of directors and councils of governors need to have a clear understanding of the circumstances when the senior independent director might intervene so that the senior independent director's intervention is not sought in respect of trivial or inappropriate matters.

If the SID is not available for any length of time, an Interim SID will be appointed by the Chair in consultation with the Board of Directors and Council of Governors, and will take on the duties as detailed above.