Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 25th October 2023

Time: 11.30 am – 2.30 pm

The Boardroom
Hengrave House
Lowes Bridge
TQ2 7AA

www.torbayandsouthdevon.nhs.uk

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TSDFT Public Board of Directors

25/10/2023 11:30

Torbay and South Devon NHS Foundation Trust

6.	Reports of the Chairman and the Chief Executive			55
	6.1 Report of the Chairman Receive and Note	Ch	12:00-12:10	
	6.2 Chief Executive's Report Receive and Note	CEO	12:10-12:25	55
7.	Safe Quality Care and Best Experience			70
	7.1 Integrated Performance Report (IPR): Month 6 2023/24 (September 2023 data) Receive and Note	HCSD	12:25-12:40	70
	7.2 Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training Receive and Note	IMD	12:40-12:50	126
	7.3 Maternity Governance & Safety Report (1July 2023 – 30 September 2023) Receive and Note	CNO	12:50-13:00	131
	7.4 BREAK		13:00-13:10	
8.	Valuing our Workforce			165
	8.1 Culture Update Approve	CPO	13:10-13:25	165
9.	Well Led			179
	9.1 Updated Trust Constitution Approve	DCG	13:25-13:35	179
	9.2 Board Assurance Framework and Corporate Risk Register Receive and Note	DCG	13:35-13:45	388
10.	Compliance Issues			
11.	Any other business notified in Advance			
12.	Date and time of Next Meeting - 11.30am, Wednesday 29 November 2023			

NHS
Torbay and South Devon
NHS Foundation Trust

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

Torbay and South Devon NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST PUBLIC BOARD OF DIRECTORS MEETING HELD IN THE BOARDROOM, HENAGRAVE HOUSE AT 11:30AM ON 27 SEPTEMBER 2023

Present:	Sir Richard Ibbotson	Chairman
	Mrs Liz Davenport	Chief Executive Officer
	Mr M Brice	Interim Chief Finance Officer
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Ms A Jones	Deputy Chief Executive and Director of Transformation and Partnerships
	Dr C Lissett	Interim Medical Director
	Mrs E Long	Director of Corporate Governance and Trust Company Secretary
	Mrs J Lyttle	Non-Executive Director
	Mrs V Matthews	Non-Executive Director
	Mr P Richards	Non-Executive Director
	Mr J Scott	Chief Operating Officer
	Ms S Walker-McAllister	Non-Executive Director
	Dr J Watson	Health and Care Strategy Director
	Dr M Westwood	Chief People Officer
In attendance:	Mr J Anthony	Head of Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards (joined for agenda item 165/09/23)
	Mrs J Bassett	Director of Midwifery and Gynaecology (joined for agenda item 164/09/23)
	Mrs S Byrne	Board Secretary
	Mr R Griffiths	Patient (joined for agenda item 155/09/23)
	Mrs P Hiles	Named Nurse for Safeguarding Children (joined for agenda item 166/09/23)
	Mrs L Houlihan	Associate Director of Nursing (joined for agenda item 155/09/23)
	Mrs N McMinn	Deputy Chief Nurse
	Mrs E Preston	Senior Sister for MAAT & Virtual Ward Unit

152/09/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

153/09/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Prof. C Balch; Mr R Sutton; Ms D Kelly, with Mrs N McMinn deputising.

154/09/23 **Declarations of Interest**

The Board noted the following declarations of interest from:

- Mr P Richards, had been appointed as a part time management consultant for 4OC Limited; and
- Mrs V Matthews, had been appointed as the Chief People Officer for the Open University.

155/09/23 **Patient Story**

Mr Griffiths attended the Board with Mrs Houlihan and Mrs Preston. He explained he was referred to the cardiology virtual ward through the community team in August 2023, due to a history of shortness of breath and bilateral leg swelling. Historically, he would have been admitted to Hospital but, that was not his wish as he much preferred the comfort of his own home; and therefore the virtual ward offer suited his needs perfectly well. He said he received good compassionate care and felt he was in control of his condition.

Mrs Davenport reflected on how people experience change in how services are delivered and asked what his advice would be to other people who might need the service in the future he said he said, for people not to be nervous, you are always kept informed.

Dr Watson explained the Cardiology Virtual Ward was currently only funded for one year but a business case was being prepared.

The Board received and noted the patient story.

156/09/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

For Approval

157/09/23 **Unconfirmed Minutes of the Meeting held on the 26 July 2023 and Outstanding Actions**

The Board approved the minutes of the meeting held on 26 July 2023.

The Board approved the minutes of the meeting held on

Consent Agenda (Pre-notified questions)

158/09/23 **Committee Reports**

The Board received and noted the Committee Reports.

Reports from the Executive Directors (for noting)

159/09/23 **Chief Operating Officer's Report - September 2023**

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

Reports of the Chairman and Chief Executive

160/09/23 **Report of the Chairman**

The Chairman verbally briefed the Board on the following:

- The Trust Long Service Award process was now established and to date 800 members of staff who have given 25 years or more NHS service were being recognised across the footprint.
- A Governor Tour of the acute site was well received on 9 August 2023, with Prof. Balch and Mr Knights supporting.
- On the 27 August 2023 the League of Friends held their first 'Bed Push' since the lifting of the Covid19 restrictions.
- Ms Jones, the Trusts Director of Transformation and Partnerships; was appointed as Deputy Chief Executive Officer for an interim period of six months as of 1 September 2023.
- On 30 August 2023 he attended the Library Photographic Competition alongside Mrs Davenport in The Horizon Centre and presented the awards to the winners.
- Following the Lucy Letby verdict Chairs and Chief Executives were called to an NHSE meeting in London. He confirmed we are actively working with the support of the South West Neonatal Network. A number of steps had already been undertaken to strengthen the systems and processes in place.
- A Governor tour of Totnes Community Hospital took place, which gave the Governors an invaluable insight into how the Integrated Care Organisation worked.
- The Chaplaincy Volunteers retirement event took place on 13 September 2023 and the Chairman attended with Mrs Davenport.
- After an interview process the following candidates were successful in securing Non-Executive Director roles within the Trust, Martin Beaman and Barbara Gregory.

- The Annual Members Meeting took place on 21 September 2023, he commended the video which was narrated by young service users.
- It would be Mrs Jacqui Lyttle's last Board as a Trust Non-Executive Director after her 9 year tenure. He thanked her on behalf of the Trust for her commitment and enthusiasm.

The Board received and noted the report of the Chairman.

161/09/23 **Chief Executive's Report**

The Board received the report of the Chief Executive from the Deputy Executive, as circulated. Ms Jones informed the Board of the following:

The Winter Plan: Following engagement at local and system level the draft of the Trust's winter plan had been received and a review by the Board had been undertaken.

New Operational Pressures Escalation Levels (OPEL) Framework: The new OPEL Framework had been received and the Trust were working with operational and system colleagues to implement and embed the framework.

Ms Walker-McAllister asked if the same OPEL Framework was applied to the community. Mrs Davenport explained the OPEL Framework was for acute settings but, as an organisation, local system and Devon system monitoring of community settings and social care was undertaken and fed into escalation processes.

Vaccinations: The Covid19 and Flu vaccination hub had been established in Bay View Restaurant and to date a great uptake had been seen.

Improving Access to scans and investigations: In partnership with NHSE and InHealth a new Community Diagnostic Centre would be open to the local population in Market Street, Torquay by spring 2024.

CQC Report: The CQC Inspection took place on the 12 and 13 July 2023 the full report was awaited where upon an opportunity for the Trust to undertake a factual accuracy check would be undertaken.

Industrial Action: Further industrial action had been scheduled by Junior Dr's, Consultants and Radiographers between the 2 and 4 October 2023. The Trust were continuing to proactively manage the impact and mitigate risks but were aware elective activity was likely to be impacted.

Lucy Letby case: The Trust had undertaken a robust review of the child death process and a review of the Medical Examiner process; at present there were no concerns to report. Mrs McMinn explained the implementation of the Patient Safety Implement Response Framework (PSIRF) would enable there to be a sharper focus on incident data.

Sexual Misconduct in Surgery findings: The Trust promoted a healthy culture at work and there was no place in its operating theatres, wards, clinics or any other services of sexual misconduct as described in the report. The Trust encouraged people to speak to the Freedom to Speak Up Guardian or use the online anonymous

platform to raise concerns. Also, the Trusts digital future programme team were developing a sexual harassment virtual reality workshop with the support of Jacqui Rees-Lee and Dr Bijal O'Gara.

Dr Westwood explained listening, acting and inclusion were vital to support people coming forward in difficult circumstances and this would be supported by the compassionate leadership work that the Trust had undertaken but, resourcing the implementation of the work needed to be given further consideration. Mrs McMinn confirmed the Patient Safety Strategy also supported raising concerns.

2022 Inpatient survey: The survey results showed improvement; but there continued to be the need for the Trust to focus on reducing noise on its wards, a comfortable night's sleep and requesting patient feedback she confirmed, an action plan was in place.

Junior Doctors: The new cohort of Junior Doctors joined the Trust in August 2023 and are now embedded in to their clinical roles.

Dementia conference: On the 6 September 2023 the Trust hosted a Dementia Conference with the aim of improving the care for those living with the condition.

Innovation by care team national award: The Post Anaesthetic Care Unit had been short listed for acuity based patient allocation in the Theatre and Surgical Nursing Category of the Nursing Times Awards 2023.

Healthcare Assistant national nursing award: Tara Johnson, a Healthcare Assistant who worked within the Emergency Department had been shortlisted for nursing support worker award by a colleague in recognition of her efforts to improve the services offered to Children and Young People cared for by the department.

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

Safe Quality Care and Best Experience

162/09/23 **Integrated Performance Report (IPR): Month 5 2022/23 (August 2023 data)**

Mr Brice presented the Integrated Performance Report for Month 5 2023/24, as circulated, and asked the Board to note:

Quality

- There was one severe incident of harm reported the Strategic Executive Information System (StEIS) and two deaths.
- There had been an increase in the number of Norovirus cases reported across wards, which had resulted in a significant increase in bed numbers.
- One late foetal loss had been reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE).
- The new implementation tool to enable providers to assess compliance against Savings Babies Lives version 3 had been published.

- The Registered Nurse day fill rate had increased to 97.9%; with a decrease in the Registered Nurse night fill rate to 88.7%.

Workforce

- The Junior Doctor rotation had been anticipated and had been undertaken.
- Workforce was one of the key factors affecting specialities that were challenged in delivering the Referral to Treatment Trajectories and therefore system collaborative recruitment was being undertaken.
- Mandatory Training Compliance performed well at 91.97%; however the Trust remained challenged with Manual Handling Training at 78%; and Information Governance Training at 87%.

Performance

- The Trust remained in Tier 1 performance for Planned Care and Urgent and Emergency Care but, were no longer in Tier 1 for Cancer.
- The Ambulance handover time had increased to 1707 reported hours lost in month.
- The Trust's 4 hour performance improved to 67.9%.
- The Trust had continued to meet the No Criteria to Reside trajectory.
- The trajectory to reduce the number of patients waiting over 78 weeks was not met with 156 waiting against a trajectory of 130.
- The Trust was meeting the Cancer faster diagnosis standard and was meeting agreed trajectories for 62 day standards.

Finance

- An adverse financial variance to plan of £1.29m was reported, which had been driven by Industrial Action.

The Board received and noted the Integrated Performance Report (IPR): Month 5 2022/23 (August 2023 data)

163/09/23 **September 2023 Mortality Safety Scorecard**

Dr Lissett presented the September 2023 Mortality Safety Scorecard, as circulated. She confirmed:

- Preparations were underway to ensure from April 2024 community deaths would also be accounted for in the Mortality Safety Scorecard.
- In proportion to peers the Trust was performing reasonably well.
- Weekend mortality rates mortality rates and challenges were highlighted and it was confirmed that the reasons behind this were understood.
- Focused mortality reviews of neonatal deaths were always undertaken and the two deaths mentioned with the report were to be expected.
- Appropriate support in respect of admission avoidance was under review for people at end of life.

The Board received and noted the September 2023 Mortality Safety Scorecard.

164/09/23 **Maternity Workforce Oversight Report**

Mrs Bassett presented the Maternity Workforce Oversight Report, as circulated. She asked the Board to note:

- There was good compliance with staff levels meeting acuity levels.
- The ongoing approach to retention.
- The recruitment challenges mirrored those nationally and had been compounded by the large uplift in establishment.
- NHSE funded national posts were positive for succession planning but were taking Midwives out of the Trusts establishment.
- Following significant consultation from the 20 November 2023 the On Call shift model would change.
- The Obstetric workforce remained challenged and a full service review with the support of the Executive Team was being undertaken.
- A reduction in red flags between January and June 2023 could be seen.

Mrs Davenport asked what the implications would be to continuity of care when the On Call shift model changed. Mrs Bassett confirmed there would be minimal impact as the teams of six would remain and historically there had always been difficulty having a member of each team on shift. She explained the Trust were not held to account for continuity of care but, it was considered as 'Gold Standard'.

Mr Currie highlights the challenges the Obstetrics and Gynaecology Department faced had been recognised in the National Obstetrics Report, as the Trust's unit was small.

The Board received and note the Maternity Workforce Oversight Report

165/09/23 **Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards**

Mr Anthony presented the Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards as circulated, to the Board. He asked the Board to note:

- There had been operational challenges but, core functions had been maintained.
- Learning had been embedded into the Trust from the Adult Safeguarding Reviews undertaken.
- A new set of principles had been published in respect of outcomes for people with multiple complex needs, with a focus on early intervention.
- Hidden Harm had a service user led Community Reference Group, which was raising awareness of hidden harm.
- A significant number of staff have been trained on the application of the Mental Capacity Act. There were two workshops run every week for front line staff.
- A Domestic Abuse Sexual Violence Practitioner had been appointed and was on site and accessible to both patients and staff.

The Board were made aware of the following risks:

- There was a backlog of Deprivation of Liberty Safeguard applications and an increased number had been seen from the acute setting. This was on the Risk Register and there was a plan in place to manage the risk.

Ms Jones asked in respect of the Deprivation of Liberty Safeguard risk, what was the implication for people. Mr Anthony explained the primary impact would be people did not have a legal protective framework around them. Therefore all applications have been reviewed to ensure the least restrictive option had been applied and there was regular monitoring of the waiting list, with updates if there was a noticeable deteriorating position; he assured the Board everyone is assessed against the national guidance.

The Board received and noted the Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards.

166/09/23 **Safeguarding Children - Annual Board Report - April 2022 - March 2023**

Mrs Hiles presented the Safeguarding Children - Annual Board Report, as circulated, to the Board. She highlighted:

Service improvements:

- Had been seen through Multi-Agency Safeguarding Hub meetings, dip sampling and thematic review programmes.

The Chairman reflected on the benefits a system working together using prevention method rather than reactive methods would drive; Mrs Hiles confirmed this was what the Child Safeguarding Team were aiming for.

Areas of challenge:

- Capacity within the Devon Multi-Agency Safeguarding Hub.
- The OFSTED inspection.
- Monitoring Safeguarding referrals trust wide, this had been placed on the Risk Register and an IT project had been agreed.

Ms Jones acknowledged the limitations the current IT infrastructure had and confirmed when the EPR was implemented data flow would improve but, in the interim asked whether everything within teams' gift was being utilised. Mrs Hiles explained it was but, the IT systems made it difficult for teams to be proactive.

The improvement plan:

- Significant improvement had been seen in levels 1-3 Child Safeguarding Mandatory Training.
- The Trust's child death reporting processes were to be updated to ensure the information site within the Child Health Governance system.

Mrs Davenport said the Trust's Child Safeguarding team were in a strong position ahead of a full service review as they took learning from incidences, local and national reviews and have strong system working. They had embedded the programme of work following the Audit.

The Board received and noted the Safeguarding Children - Annual Board Report.

167/09/23 **Infection Prevention Control Annual Report**

Dr Watson presented the 2022-2023 Infection Prevention Control Annual Report, as circulated. She highlighted:

- C-Diff stood out as an alert organism and the team were committed to reducing this.
- The Trust had a stringent approach to maintaining lower covid levels, below the national average of 7%.
- The Trusts small number of single rooms meant the ability to isolate patients was compromised.
- There was likely to be a different pattern of infection for 2023 to 2024.

The Board approved the Infection Prevention Control Annual Report

Well Led

168/09/23 **Annual Strategic Agreement Summary**

Mr Scott, presented the Annual Strategic Agreement Summary, as circulated. He said:

- The Trust's ICO model enabled people to be cared for in a way that suited them and their needs and the Annual Strategic Agreement Summary reflected this.

The Chairman was supportive of the ICO strategy continuing to move forward as the prevention agenda, which was part of the Trusts strategy, was more effective and less costly.

Mrs Davenport explained there was more research required for everyone to understand the measurable impact that an ICO had and the way the model benefits its population. Ms Jones agreed for the Strategy Group to undertake an assessment of the impact the ICO has had on the population it served. **ACTION: Ms Jones**

The Board approved the

169/09/23 **Trust Strategy Update – September 2023**

Ms Jones presented the Trust Strategy Update, as circulated. She confirmed:

- The Trust Strategy had been reviewed by the BBF committee it continued to meet the delivery of the strategic enabling plans.
- The work undertaken to review the Trust Strategy had been deemed fit for purpose and aligned to the One Devon System joint forward plan.
- Work would be undertaken to ensure the Medium Term Financial Plan and the Trust Strategy aligned.
- The Team would support the Director of Corporate Governance to develop its Board Assurance Framework entry.

The Board approved the Trust Strategy Update.

170/09/23 **Board Assurance Framework and Corporate Risk Register**

Mrs Davenport presented the Board Assurance Framework and Corporate Risk Register, as circulated to the Board.

Mr Crompton noted that the Industrial Action impacted all areas and not just operations and performance and the risk cutting across all sections of the BAF needed to be mitigated. **ACTION: LD**

The Chairman informed the Board there was no BAF Reference Section for Torbay Pharmaceutical, this was due to the confidential nature of the business but he assured the Board detailed risk assessments were regularly being undertaken.

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

171/09/23 **Fit and Proper Persons Test for Board Members**

The Chairman presented the Fit and Proper Persons Test for Board Members as circulated. He confirmed the framework was under development and would be effective from the end of September 2023.

The Board received and noted the Fit and Proper Persons Test for Board Members.

172/09/23 **Compliance Issues**

173/09/23 **Any other business notified in advance**

174/09/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 25 October 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 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. 30.11.22 Ms Kelly confirmed two designs and a place for the memorial had been decided upon, the Trust were awaiting costings. 25.01.23 Ms Kelly confirmed the location of the memorial had been agreed but the Trust were awaiting a date for installation. 22.02.23 Ms Kelly confirmed Lottie was engaged with the Organ Donation memorial and site location. 29.03.23 Ms Kelly confirmed engagement with Lottie was ongoing. 26.04.23 Ms Kelly confirmed engagement with Lottie was ongoing. 28.06.23	28.09.22

			Ms Kelly confirmed a League of Friends funding application had been made to support the memorial. 26.07.23 Lottie raised a significant amount and LoF. Socialising the design and in the current climate confident we have the right design to build up the funding pot. Thank Nikki, Consultant Intensivist, advocated and leading this. Nikki Freeman	
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 Mrs Davenport will report back to the Board with a date for the Board to Board with DPT. 28.06.23 Mrs Davenport confirmed a review between Devon Partnership Trust and Child Family Health Devon was currently being undertaken and a Board to Board was likely to take place by the middle of September 2023. 26.07.23 Mrs Davenport confirmed the Board to Board would take place in Autumn 2023.	26.04.23
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	28.06.23 Mrs Davenport confirmed she had escalated Learning Disability deaths to the ICS and was awaiting to hear from Naomi Atkin, CNO, Devon ICS 26.07.23	31.05.23

			Naomi Chapman had acknowledged the request and there was commitment to follow up with a formal plan. 27.09.23 The action was agreed to be closed.	
145/07/23	Ms Kelly to provide Ms Walker-McAllister a breakdown of the complaint cases that went to the Health Ombudsman and the Health and Social Care Ombudsman to consider inequity.	Ms Kelly	27.09.23 Mrs McMinn confirmed she was in receipt of the data and would forward the data to Ms Walker-McAllister today. Action closed	26.07.23
146/07/23	EDI objective to be placed on the BAF	Dr Westwood	27.09.23 Mrs Long confirmed she was to place the EDI Objective on the BAF.	26.07.23
147/07/23	EDI Charter to be placed on the Board Development Agenda	Dr Westwood	Mrs Byrne placed the item on the Board Development workplan 27.09.23 Dr Westwood confirmed the EDI charter had been presented at the Board Development Session on 15.09.23 and was to be presented to Board on 25.10.23. Action closed	26.07.23
168/09/23	Ms Jones agreed for the Strategy Group to undertake an assessment of the impact the ICO has had on the population it served.	Ms Jones		27.09.23
170/09/23	The Industrial Action impact and mitigations to be reviewed across all sections of the BAF.	Mrs Davenport		27.09.23

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Report to the Trust Board of Directors			
Report title: Committee Chairs' Report			Meeting date: 25 October 2023
Report appendix:	Committee Chairs' Report		
Report sponsor:	Director of Corporate Governance and Trust Secretary		
Report author:	Corporate Governance Manager		
Report provenance:	n/a		
Description/Purpose of the report and key issues for consideration/decision:	The attached report provides the Board with a summary of the discussions held at Board sub-committees in the reporting period. To enable any issues to be easily highlighted, the report is divided into the following categories: • Alert • Advise • Assure • Risk • Celebrating Outstanding Minutes of the meetings can be found within the Diligent online library: Hyperlink: Diligent Boards: South Devon Health Information Services: Resource Center Location: Diligent sign-in>Resource Center>TSDFT Board and Sub-Committee Minutes		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to note: • the Committee meetings held since the last meeting; and • any exception reporting of Committee Chairs.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	In providing the Board with a high-level report of the activities of the Committees that have met in the reporting period, it gives the Board with opportunity to consider if any action needs to be taken to support any areas of concern that might impact on its population.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources The report provides information that will enable the Board of Directors to support the Triple Aim.		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards		

	Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	N/a
External standards affected by this report and associated risks	Terms of authorisation, NHS England licence and regulations National policy, guidance

Chairs' Report
Board Sub-Committees
25 October 2023

Torbay and South Devon NHS Foundation Trust

	Quality Assurance Committee 25th September 2023	FPDC 25th September 2023	Audit and Risk Committee 11th October 2023	People Committee 16th October 2023	Building a Brighter Future Committee 18th October 2023
ALERT: Alert to matters that need the Board's attention or action, eg an area of non-compliance, safety or a threat to the Trust's Strategy	• Lack of resource impacting on operational performance	• Noted the ICS MTFP and approved in principle. Greater detail required to build confidence and further work at organisational level to define time scale to deliver sustainability. • Continuing IA noted as threat to delivery of some services and performance targets.	There is an increased level of exposure and risk regarding the Adult Social Care Bi-Annual Aged Debt & Write off Position which threatens the Trust's financial sustainability.	Concerns about the experience of some colleagues with a protected characteristic, as evidenced through some of the data in the WRES and WDES reports and outlined in the update from the Trust's EDI Lead. Concern about the risk of ongoing industrial action	• Potential implications of advice from planners regarding the retention of non listed historic buildings. • Need to plan for the deflection of demand for acute hospital services and implications for investment in facilities and services in community and home settings.
ADVISE: Advise the Board of areas subject to ongoing monitoring or development or where there is negative assurance	• Deprivation of Liberty assessment backlog • Overdue adult social care reviews and initial assessments	• PIR of the business case for increase Business Improvement Capacity would be further discussed by executive. • Continuing work on stoke pathway with national team involvement and acknowledgement that peninsula wide networking required. • M5 financial position £1.29 adverse variance (sig. impact of IA) Second half of year challenging and work begun to ascertain if end of year forecast should be revised. Concerns regarding progress on £10.4m system CIP.	In reviewing our Clinical Audit and Effectiveness Annual Report 2022/23 and Clinical Audit Forward Plan 2023/24 it is recognised that although the workforce is appropriately engaged the capacity to carry out this work is challenged.	Work to ensure clinicians are engaged with revalidation processes Sickness and turnover, whilst still relatively high, are on a downward trend The potential impact of industrial action on junior doctor training days and the risk to rotas	• Independent masterplanning review has raised questions over location of proposed ward block, scope and timing of ED works, the need and potential for multi storey car park provision. • Timetable for submission, review/approval of Site Enabling OBC • Manpower and physical resources to ensure successful implementation of EPR.

Chairs' Report
Board Sub-Committees
25 October 2023

Torbay and South Devon NHS Foundation Trust

	Quality Assurance Committee 25th September 2023	FPDC 25th September 2023	Audit and Risk Committee 11th October 2023	People Committee 16th October 2023	Building a Brighter Future Committee 18th October 2023
ASSURE: Inform the Board where positive assurance has been received	• Production of the Adult Social Care Local Account Summary • Work in place to improve stroke performance through deep dive • Annual Adult and Children Safeguarding Reports • Improvements to ED environment • Improved Mortality Scorecard data	• Good ongoing performance improvement on 4hour target, discharge before noon, No Criteria to Reside & cancer targets. • Winter Plan draft received and there is a good level of assurance. • BBF Site Enabling Business Case received and good assurance on affordability of capital spending requirement. Significant transformation efficiencies required to ensure affordability of revenue implications.	Assurance was received regarding: • Board Assurance Framework and Corporate Risk Register • SIRO Annual Report • Losses and Special Payments Report • Tender Waivers Report • Risk Group Chair's Report • Internal Audit Interim Report • Counter Fraud Progress Report • Counter Fraud Annual Report	• Progress on People Promise and the coherent approach to the delivery of people related work	• EPR procurement process continues as planned and programmed • Response to Stage 2 of NHP data gathering submitted as required • Independent masterplanning review has validated site enabling works programme and location of planned care centre. • Appointment made to deliver comms and engagement component of BBF Programme
RISK: Advise the Board which risks were discussed and any new risks identified	• Deterioration in number of open incidents – improvement plan in place • Increase in the number of falls	Noted that BAF would be subject to full revision in near future,. 3.3A regarding GIRFT inconsistencies removed after significant work.	It was noted that the BAF will be updated to reflect the recent CQC inspection	Impact of NoF4 Impact of Industrial Action Transforming the organisation whilst the BAU space is so busy.	• Digital and cyber resilience risk assessment reviewed and is likely to remain above target until route to delivery of EPR confirmed. • Greater confidence in timing of approvals of site enabling business OBC. Uncertainty and risk remains over timing and confirmation of overall capital funding allocation funding for preferred way forward. • Transformation and partnerships risk assessment reviewed. Current focus is on system and acute hospital. More attention to be paid to risks in community and home based settings.

Chairs' Report
Board Sub-Committees
25 October 2023

Torbay and South Devon NHS Foundation Trust

	Quality Assurance Committee 25th September 2023	FPDC 25th September 2023	Audit and Risk Committee 11th October 2023	People Committee 16th October 2023	Building a Brighter Future Committee 18th October 2023
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding	• Sustained compliance with Nutrition and Hydration risk assessments • Reduction in 12 hour ED delays • Improvements in the number of open 72 hour reports	Excellent progress in several key performance areas. Continued evidence of good level of grip and control over CIP programme.	The current internal audit plan is being updated to incorporate areas of concern and this includes audit work in conjunction with DPT regarding the governance of CHFD.	Ongoing work to review and sign off job plans The reallocation of headcount which allows some critical roles to be filled within the People team Some good progress in the area of equality, diversity & inclusion	• Value of independent masterplanning review which has highlighted as number of key issues for examination to ensure that robust business cases can be developed.
To note: FPDC met on Monday 23rd October however due to the timing of the Committees it was too late to include feedback in this paper. Committees which have not met in the reporting period: Ethics Committee, Charitable Funds Committee					

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date: 25th October 2023
Report appendix:			
Report sponsor:	Chief Operating Officer		
Report author:	Care Group Directors		
Report provenance:	The report reflects updates from theTrust's Care Groups		
Description/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.		
Action required:	**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			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides the Trust Board with narrative information to support the Integrated Performance Report and allows for greater understanding of the issues and greater opportunity for assurance to be gained.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources Operational performance supports all three aims.		
Relevant BAF Objective(s):	Objective 5 - Operations and Performance Standards		
Risk: Risk ID: *As appropriate*			
External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance		

Report title: Chief Operating Officer's Report		**Meeting date:** 25th October 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 Care Groups.

2.0 Introduction

September has seen a rise in infection outbreak challenges with a number of infection cases impacting on beds and flow coupled with strike action across the month creating challenges in capacity and delivery.

3.0 Winter Plan

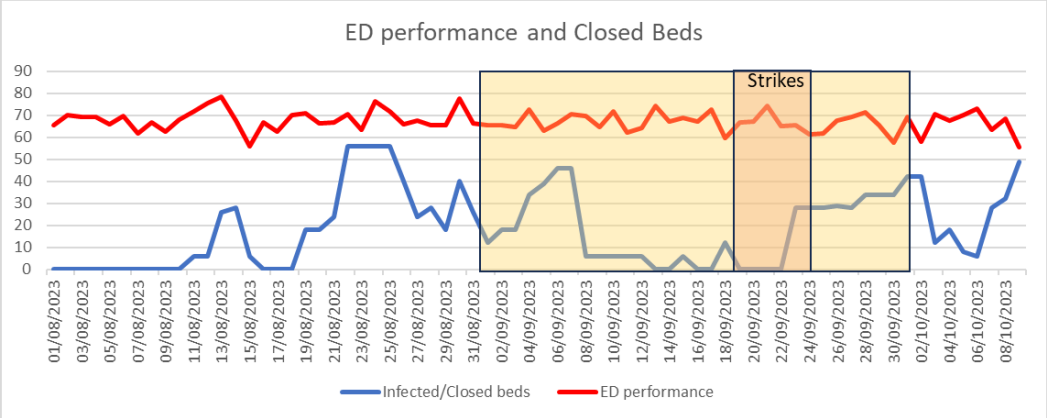
Agreed at last month's Trust Board the Winter Plan is in action. The key actions are below with updates on progression.

Winter Plan actions	Bed Impact	Comment	RAG	Current Bed Impact estimate
Initial maximum bed gap	-76			-76
Elimination of patients waiting for beds	-13			-13
Implementation of SHOP Ward rounds		SHOP ward rounds are not adopted in most wards		
Implementation of Weekend Discharges		Weekend discharges improvement is erratic		
Infection control buffer	-5	Agreed		-5
Removal of 11 esclation beds in ED	-11	Implemented		-11
Expansion of Virtual Ward capacity	21.45	Agreed but use is slow		14.16
Opening of Jack Sears Unit	5.5	Delayed		0
Expansion of SDEC	12	Works when SDEC is not bedded		5
Reduction in LOS (Community)	5.8	Delivering		5.8
	15.75			-4.04
Intermediate bed gap	-55			-80
Acute bed occupancy increase to 97%	26	Implemented		26
Development of 'Emergency Village'	6	Meetings arranged but slow to progress due to IA		3
Implementation of Surge protocol	6	Implemented		6
Virtual Ward bed occupancy increase to 95%	3.5	Bed occupancy is currently 66%		2.3
Reduction in LOS (Acute)	8	Identification of target wards incomplete		0
Reinstatment of patients waiting for beds	13	Agreed		13
Final bed gap	7.5			-30

The Winter Plan is monitored through the Winter Plan Group, which meets fortnightly, and through the Urgent and Emergency Care Improvement Group. Where actions are not yet fully delivered focus in increased to provide support and/or mitigation actions are developed.

4.0 Urgent & Emergency Care (UEC) update

September flow was impacted by both infection outbreaks and industrial action by medical staff.



In September we lost 504 bed days to infection outbreaks.

The days of industrial action had no benefit to performance delivery as large numbers of both juniors and consultants were not available to work and the ability to provide senior decision making was reduced.

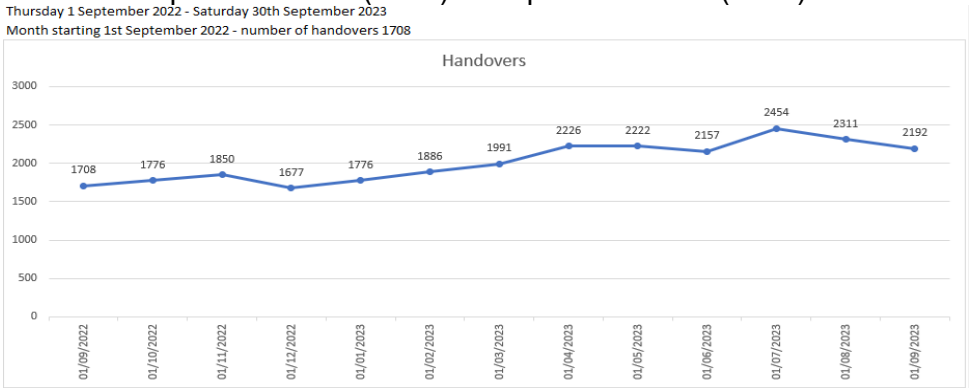
September saw 9,638 emergency and urgent care attendances for the integrated care organisation (ICO). This was an average of 321 patients per day. Whilst lower than the last two months, it is 995 patients higher than September 2022, with the main increase being in attendances to Torbay Emergency Department (ED).

Whilst performance was behind trajectory for the National Operating Framework (NOF4) recovery target of 72%, it remained steady at 68.42%. The Urgent Treatment Centre (UTC) and Minor Injuries Unit (MIU) performance remain steady at 99.06%. Nationally we were 60th out of 118 Trusts compared to being 104th in October 22 for all type performance of the 4 hour target.

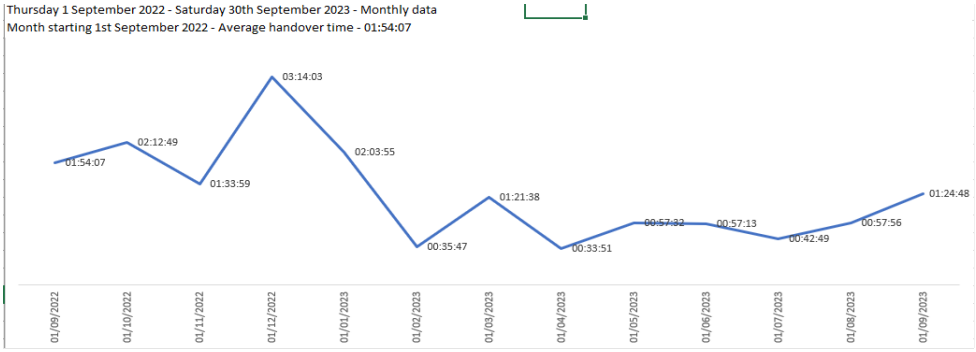
4.1 Ambulance Handovers

Ambulance handover delays increased by 74 in September compared to the previous month with 1828 arrivals over 15mins.

The trend of increased demand continues with Ambulance Handovers increased by 22% from September 2022 (1708) to September 2023 (2192).



The average time lost per ambulance to handover has decreased from 1hr 54min (including the 15 mins) in August 2022 to 1hr 24 min in September 2023.



4.2 Inpatient Flow

Across the ICO (including our community hospitals) we had 1,842 discharges. Of which 24.8% (456) of patients were discharged by noon and 72.7% (1,340) pre 5PM. The majority of our adult wards delivered more discharges compared to August. (Highlighted in green in the below table)

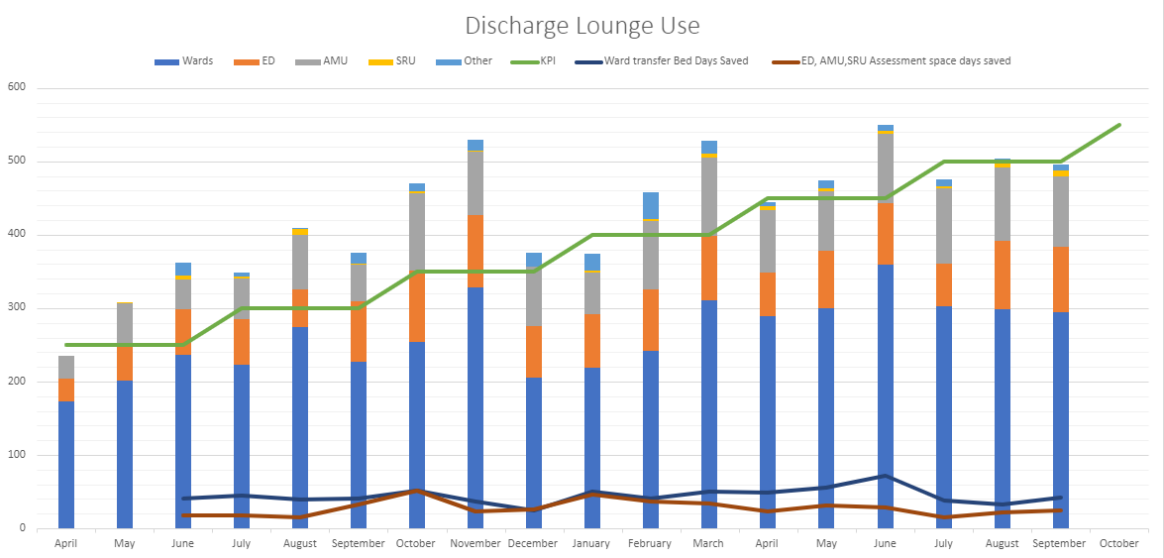
Friday 1 September 2023 - Saturday 30 September 2023

The number of discharges in this period is above or below the baseline.
Weekday target is 71%; Weekend target is 28%.
Pre-Noon target is 33%; Pre-5pm target is 75%.

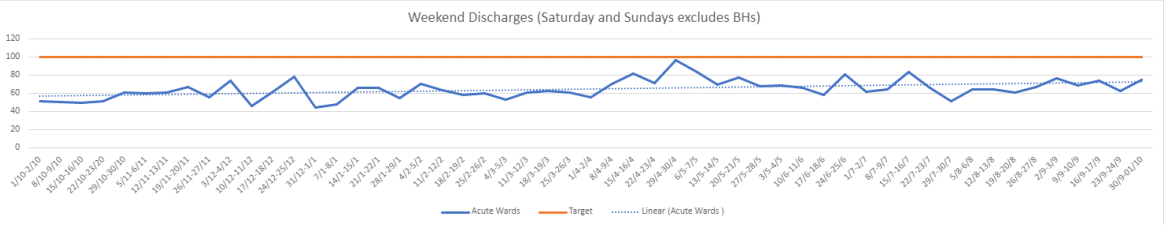
(Baseline: Wednesday 2 August 2023 - Thursday 31 August 2023)

Ward Name	Total	Discharges	Transfers to a Community Hospital	Transfers to the Discharge Lounge	Deaths	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Average LoS (Days)	# Pre Noon	% Pre Noon	# Pre 5pm	% Pre 5pm	# Weekday	% Weekday	# Weekend	% Weekend
AINSLIE	71	43	5	18	5	54	4	12	1	6.19	21	29.6%	54	76.1%	53	74.6%	18	25.4%
ALLERTON	140	120	2	9	9	128	7	4	1	6.57	16	11.4%	83	59.3%	110	78.6%	30	21.4%
BRIXHAM	40	34	2	2	2	4	22	12	2	21.08	15	37.5%	36	90.0%	32	80.0%	8	20.0%
CHEETHAM HILL	79	43	5	24	7	50	12	11	6	10.89	20	25.3%	62	78.5%	68	86.1%	11	13.9%
CHEST PAIN UNIT	43	43	0	0	0	43	0	0	0		1	2.3%	24	55.8%	32	74.4%	11	25.6%
CORONARY CARE	37	33	0	2	2	37	0	0	0	4.6	3	8.1%	24	64.9%	27	73.0%	10	27.0%
CROMIE	176	153	3	18	2	165	7	4	0	4.31	33	18.8%	135	76.7%	130	73.9%	46	26.1%
DART	31	29	1	1	0	1	12	15	3	25.02	13	41.9%	26	83.9%	28	90.3%	3	9.7%
DAWLISH	36	33	1	1	1	2	12	20	2	19.73	26	72.2%	34	94.4%	30	83.3%	6	16.7%
DUNLOP	97	87	2	4	4	85	6	5	1	8.19	22	22.7%	75	77.3%	80	82.5%	17	17.5%
EAU4	242	177	14	45	6	213	8	21	0	3.12	40	16.5%	178	73.6%	187	77.3%	55	22.7%
ELLA ROWCROFT	84	73	5	5	1	59	9	14	2	6.42	17	20.2%	58	69.0%	68	81.0%	16	19.0%
FORREST	94	51	6	27	10	67	8	15	4	9.17	22	23.4%	65	69.1%	75	79.8%	19	20.2%
GEORGE EARLE	117	81	17	10	9	53	33	30	1	7.52	16	13.7%	70	59.8%	98	83.8%	19	16.2%
MCCALLUM	77	27	6	44	0	17	31	26	3	12.47	49	63.6%	68	88.3%	69	89.6%	8	10.4%
MIDGLEY	120	62	4	48	6	96	9	15	0	6.04	29	24.2%	86	71.7%	101	84.2%	19	15.8%
SIMPSON	73	43	2	25	3	49	6	16	2	10.61	24	32.9%	51	69.9%	65	89.0%	8	11.0%
TEIGN WARD	49	45	1	0	3	6	33	8	2		28	57.1%	43	87.8%	41	83.7%	8	16.3%
TEMPLAR WARD	38	33	4	0	1	7	17	13	1		20	52.6%	33	86.8%	33	86.8%	5	13.2%
TURNER	66	56	2	3	5	52	8	4	2	9.49	13	19.7%	39	59.1%	51	77.3%	15	22.7%
WARRINGTON	132	114	2	13	3	128	1	3	0	3.67	28	21.2%	96	72.7%	104	78.8%	28	21.2%
Grand Total	**1,842**	**1,380**	**84**	**299**	**79**	**1,316**	**245**	**248**	**33**	**8.4**	**456**	**24.8%**	**1,340**	**72.7%**	**1,482**	**80.5%**	**360**	**19.5%**

Due to continued infection outbreak pressures and industrial action, overnight bedding of the lounge occurred resulting in 5 patients less than its KPI of 500 patients using the facility. 295 patients were from our adult base wards, this generated the equivalent of 42 released bed days.



We continue to manage our adult inpatient wards at maximum capacity and therefore are focused on opportunities to improve our patient flow.



Weekend discharges continue to be below expectation. In September, on average we discharge 71 patients across the weekend, which is 29 patients below the target, but an improvement from August. The flow and improvement group are working with teams to improve this. Part of this work includes changing the system we use to generate a working list of patients for our multidisciplinary team (MDT).

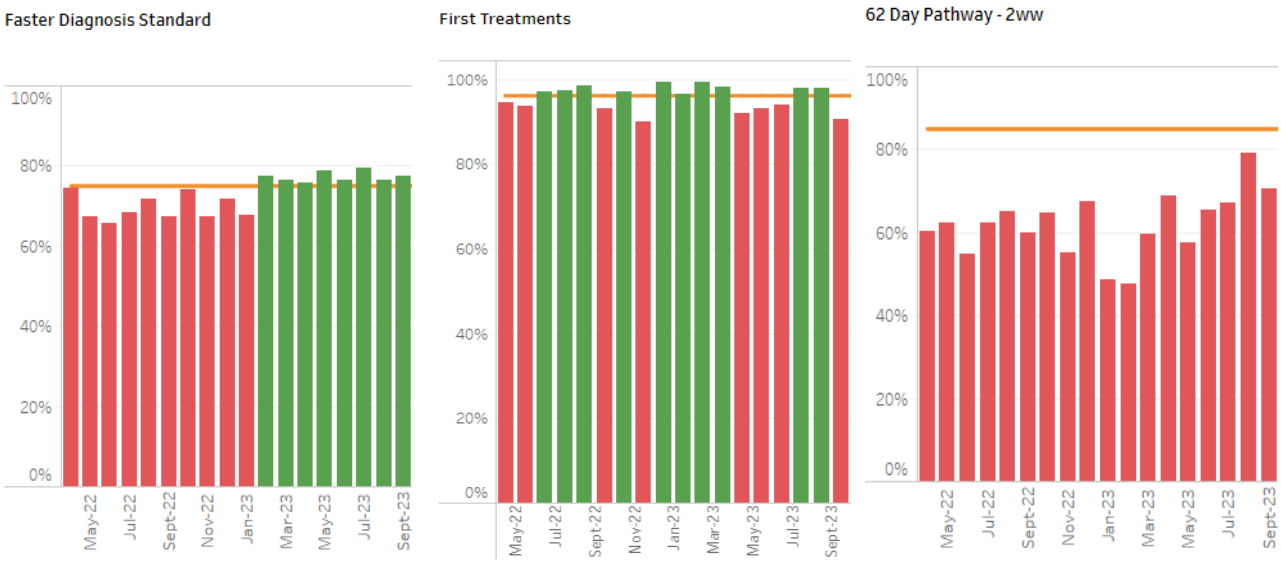
5.0 Cancer Demand

Torbay and South Devon received 2,003 urgent, suspected cancer referrals in September. Therefore, in the first half of 2023/24, the Trust has received 11,680 referrals, compared to 11,155 in 2022/23 (which equates to year-on-year growth of 4.7%).

Breast, Gynae and Skin continue to receive above average referral growth, with each site seeing increases of over 10%.

5.1 Cancer Performance

The 'Key Lines of Enquiry', which are the priority measures monitored by NHS England are.



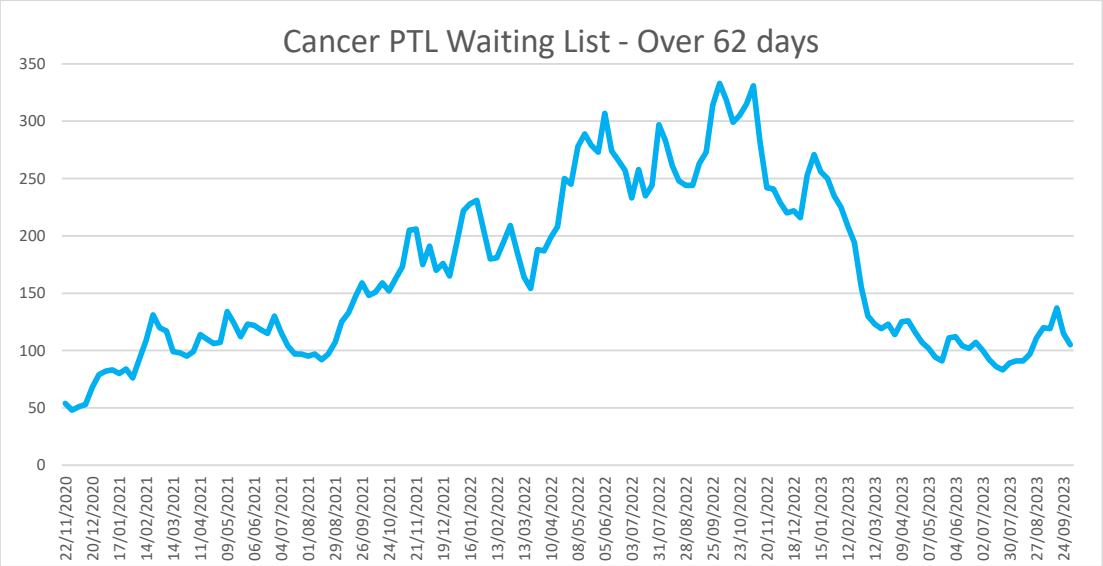
The Trust continues to achieve the 28-day Faster Diagnosis Standard with performance at 76.9% in September. Maintenance of endoscopy waiting times in Colorectal and biopsy waits in Urology have been the key influences.

31-day performance is currently at 90.4%, against the 96% target. Half of the breaches are due to the ongoing capacity constraints in plastic surgery, a service delivered with Royal Devon University Hospital (RDUH). The remaining breaches are accounted for across multiple specialties and are a culmination of several factors, all of these are shared with individual service leads to feedback into service improvement.
We continue to see a positive trajectory for the 62-day standard, which represents the consistent work in our backlog reduction initiatives. For September, this metric is expected to be 70.2% (85% standard).

Over 62-day Backlog (Open Pathways)

As of 2nd October 2023, the number of open pathways over 62-days was 105 and represents 5.4% of the total patient tracking list (PTL). There were only eleven patients over 104 days.

This position places Torbay 28th of all Trusts nationally, 2nd in the South West Region, and best in Devon.



Outlook

For October so far, we are starting to see a slight increase in the wait for first appointments. This is particularly evident in Urology, Colorectal and Gynaecology – all services that needed to cancel outpatient activity to maintain a safe service over the recent strikes. These waiting times have started to recover with additional activity taking place in Urology and Colorectal.

This month, we have opened our new endoscopy decontamination unit and are on track to open the new endoscopy suites by the end of November; these will provide the much-needed infrastructure to deliver colorectal diagnostic activity. In Urology, this month also saw the opening of their new Procedure Room in Paignton, this completes the repurposing of this community site to be a hub for all urology activity. The new procedure room will allow template biopsies, among other procedures, to be performed, releasing capacity in the main day surgery unit.

The gynaecology position remains fragile. The culmination of demand increases, competing obstetric pressures, staff absence and strike activity has led to a rise in waiting times. This is partially notable for post-menopausal bleeding (PMB) clinics, currently at 5 weeks. We are implementing extra weekend sessions and have allocated additional operational performance support to resolve this.
For longer term resilience, the service is undertaking a robust workforce review. National legislative changes to maternity care provision, such as the Ockenden report recommendations, have increased the labour ward and obstetric resource that is required.

New Cancer Waiting Time standards – October 2023

As of the 1st October, the new cancer waiting time standards are live and will feature in our future reports, including the Integrated Performance Report (IPR).

Last month's Chief Operating Officer's (COO) report included a detailed look at the changes to the national Cancer Waiting Time standards. As a reminder, the cancer standards have been consolidated from 9 constitutional measures into 3.

- the 28 Day Faster Diagnosis Standard (75% target) and removal of the 14-day, two-week wait standard.

- one headline 62-day referral to treatment standard, combining previously separate Consultant Upgrade and Screening standards (85%)
- one headline 31-day decision to treat to treatment standard (96%), combining the current First and Subsequent treatment standards.

6.0 Referral to Treatment (RTT)

6.1 Long waits (August 2023)

- **104 weeks –** The Trust has reported no 104 week waits since March 23.

- **78 and 65 weeks –** The Trust had submitted an updated forecast based on improved clearance rates for our 78 and 65 week cohorts. The Trust forecasted that all 65 and 78 week patients will be cleared by 31st March 2024.

		June Q1	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
78 week	Forecact Plan	130	130	130	111	92	73	65	35	19	0
	Actual	123	129	156	189						
	Total	-7	-1	26	78	0	0	0	0	0	0

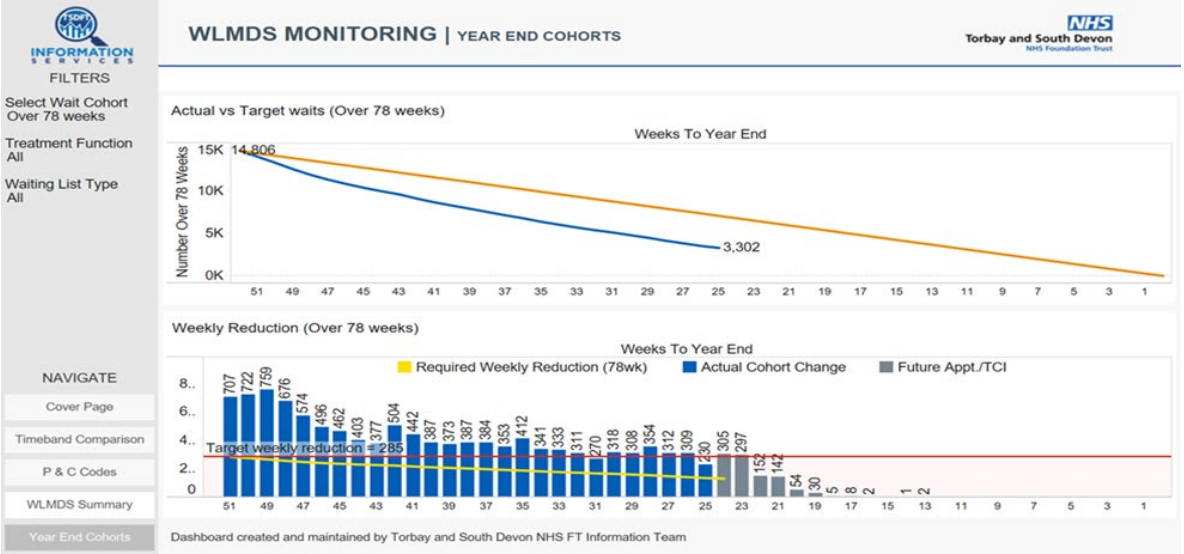
		June Q1	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
65 week	Forecast Plan	1312	1307	1387	1189	991	793	650	397	199	0
	Actual	1196	1,169	1296	1180						
	Variance	-116	-138	-91	-9	0	0	0	0	0	0

Progress against these plans has been positive throughout Q1 and July but has now come under pressure from the impact of Industrial Action (IA).

August was the first month that our control totals were not met for 78 weeks, missing the target by 26. Our performance against our 78-week plan has deteriorated further in September, however our 65 week clearance rate remains on track.

Whilst our "in month" performance against actual breaches has been maintained the loss of critical capacity in the first 6 months of the year due to Industrial Action has had a negative impact on our planned clearance of future long waiters. To date (Apr – Oct) c4,500 clinical events have been lost to Industrial Action, of these it is estimated that c1,100 would have been clock stop events. The impact of strikes is growing as they become more co-ordinated. Strike actions in September and Oct caused 30% more disruption than previous strikes.

Plans to mitigate this position are under review, this work will include the Devon ICB to ensure Devon wide solutions can be explored for our most "at risk" services.



Our clearance of the 65-week cohort remains ahead of plan, this position will come under pressure if the current pattern of strike actions continues.

6.2 Protecting and Expanding Elective Services
65-week cohort - 1st Outpatient appointment by 31st October
Booking rates for most services are ahead of the rates required to achieve a 1st outpatient appointment for all 65-week cohort patients by 31st October. Since mid-August the undated position has almost halved and now stands at 2,794.

Endocrinology and Paediatrics are out of scope because of the high level of clock stops at 1st outpatient appointment. The focus for these 2 specialties will be full clearance of the cohort by 31st March 2024.

Booking this cohort has been impacted on by Industrial Action as clinics have been stood down. Of the c4,500 lost clinical events, c4,100 are in outpatients, this has increased our remaining risks against the booking target in the following specialties:

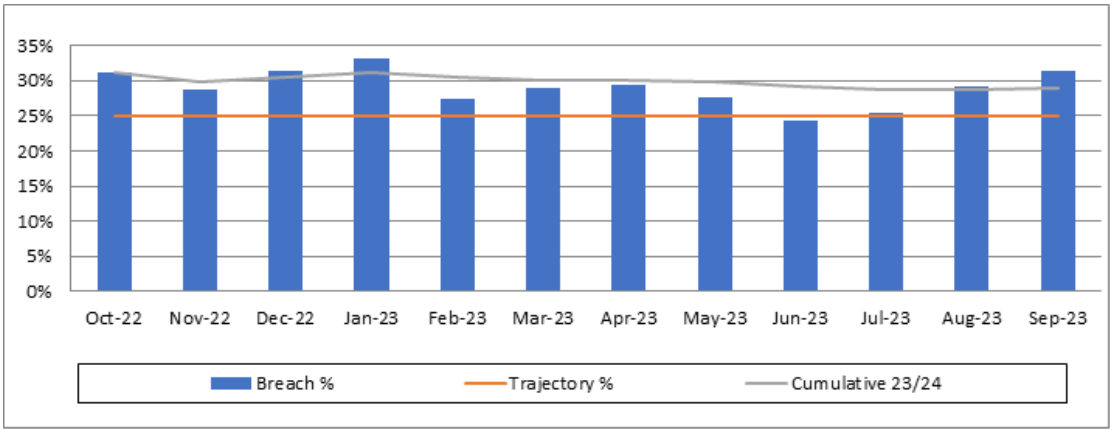
Specialty & current risk	Mitigations	Remaining risk
ENT - 492 undated	Medinet Super Clinics	400
Gynae 261 undated	Medefer & Medac IS	200
Ophthalmology 233 undated	18 weeks. Extra inhouse. Glaucoma Locum	100
Oral Surgery 505 undated	Weekend clinics , convert Operating to OPA	400
T&O 416 undated	Glanso, extra inhouse. Mutual aid request	Plans to fully mitigate

Other measures to further mitigate this position including clinical and technical validation will continue to be explored alongside leveraging the Medefer care model to other at risk specialties.

Validation activities
We are required to validate a minimum of 90% of patients waiting longer than 12 weeks in a 12 week cycle. A combination of Patient contact, technical and clinical validation is currently delivering 57% against the target of 90%. Further support has been agreed with the Devon ICB which will increase patient contacts from 500 per week to 1,000. This will push our position to 76% by the end of October and deliver 90% by the end of Q3.

NHS England Support
We have worked closely with Michael Wilson and the NHS England support team and have recently successfully bid for funding (£80K) from the Further:Faster program. This funding will be used to create more program management and operational capacity.

7.0 Diagnostics Performance
Our diagnostic performance continued to worsen in September. The Trust reported 31.47% of patients waiting longer than six weeks against the end of September target of 25%. (August position 29%). The 23/24 Operating plan target for March 2024 is 15%.



Capacity in September remained challenged with further industrial action and pathway changes which has increased the demand on inpatient services.

- MRI remains a challenge but has remained static at 35%.
- CT performance has deteriorated from 11% in August to 13% in September but remains in target.
- Non-obstetric ultrasound has worsened from 20% in August to 22% in September but also remains in target.

Echocardiology (August 27%) continues to deteriorate in September at 31% and colonoscopy (71%), flexible sigmoidoscopy (64%), cystoscopy (47%) and gastroscopy (64%) remain in a breached position in September. Work is being undertaken in these areas to look at the patient level data to determine what actions can be taken to mitigate further decline in performance.

DM01 Forecast – March 2024, target 15%
Owing to uncertainty around further strike action and the need to factor in the impact so far and potential impact of further strikes , the forecast is being reviewed by the BI team and Radiology and will provide an update in the October COO report.

8 Children and Family Health Devon (CFHD)

8.1 Performance - Waiting times

The chart below shows the non-reportable (non-consultant -led) RTT for all CFHD service areas.

Overall RTT (Incomplete Pathway)

Service	Mean Wait	% waiting ≤ 18 weeks	% RTT ≤ 18 weeks over the last 12 months
Community Children's Nursing (CFH Devon)	7.0	92.9%	
Learning Disability (CFH Devon)	2.7	100.0%	
Mental Health and Wellbeing (CFHD)	17.3	58.7%	
Occupational Therapy (CFH Devon)	24.4	37.4%	
Palliative Care (CFH Devon)	Null	Null	
Physiotherapy (CFH Devon)	9.7	87.9%	
Special School Nursing (CFH Devon)	Null	Null	
Specialist Autism Spectrum Assessment Team (CFHD)	43.7	28.3%	
Specialist Children's Assessment Centre (CFHD)	51.7	24.4%	
Speech & Language Therapy (CFH Devon)	37.3	31.2%	

Notable issues regarding waits include the following:

Speech and Language Therapy (SALT): there has been a 30% reduction in the numbers waiting in Torbay since March 2023 as a result of a realignment of SALT resources and new ways of working.

Community Nursing: mean waits have reduced significantly (currently 2.7 weeks) now that the service has resumed delivery of the core service only i.e. ceased providing the routine phlebotomy service which was delivered to support the acute trusts during Covid.

Autism Assessment Service: there has been a steady increase in the numbers of children waiting due to an increase in the annual referral rate since 2019/20 of 37%, and monthly rate by 84% YTD since April 2023.

It should be noted that autism waits are monitored in Devon and Torbay by NHSE and the Department for Education (DfE) as they are a part of the improvement plans following the Devon Area SEND re-visit by Ofsted and CQC in May 2022 and the Torbay Special Educational Needs and Disability (SEND) inspection in November 2021. It is acknowledged by the Integrated Care Board (ICB) and partners that it is not possible to reduce waits and to meet the improvement target waits without increased clinical capacity / additional investment and system change. Work to identify resolution to this matter is currently under consideration.

Long Term Plan Deliverables: Children / young people's mental health
8.2 Transformation
As previously reported, work continues to prepare to mobilise the new service model. Notable developments in the month include the following:

- Finalising the new Referral Form, co-produced with parent-carers and young people
- Consultation with CFHD Clinical Reference Group and agreement on process mapping for new Clinical Triage and MDT locality assessment clinics
- Agreement regarding functionality of the referral process within the new website and commencement of development
- Development of standard documentation such as the new Clinical Assessment, and Clinical Screening templates
- Co-production to determine clinical pathway names
- System One development
- Continued staff engagement regarding change process through whole service meetings
- Patient Initiated Follow Up (PIFU) process designed and being piloted in Physiotherapy service
- Initiation of workshops with clinical leaders/ teams to develop detailed specifications for clinical pathways (in light of specification review work with the ICB).

9.0 Families Community and Home Care Group Update

9.1 Child Health / Paediatrics This year Child Health staff have been engaged in a programme of work to transform services with the aim of delivering high quality and safe care, reducing waits, and meeting our financial envelope. Examples of recent projects include:

- Process, pathway and documentation improvements within several pathways including Blue Star Babies, Eating Disorders, Rheumatology, Endocrinology, Epilepsy and Allergies.
- A digital epilepsy training package went live in mid-September 2023, enabling stakeholders across the community (e.g., teachers, social workers, school nurses) to access training on management of epilepsy within their professional setting and significantly reducing time taken to train colleagues by the paediatric specialist nurses, creating capacity for direct patient care.
- Ward clerk competencies framework developed. Buddy system in place for new starters.
- CPS process and pathways developed, and recent CPS completion has improved significantly.
- Well organised ward sessions held on Louisa Cary and SCBU (nursing areas, reception spaces) to improve ergonomics, safety, and flow.

The team have also been focused on improving co-design with children, young people, and their families and as part of this work inpatient surveys have been completed by the Trust's engagement lead and sent to Healthwatch to collate as part of the Peninsula Acute Sustainability Plan. Financial support has been sourced to fund two patient panels (one for teenagers and one for parents).

The ongoing industrial action continues to be the greatest risk to reducing long waits and achieving our financial targets.

9.2 Children's Torbay 0-19 Service

During quarter 1 there has been an improvement in performance figures for new birth visits undertaken by the Public Health Nursing team, compared with the quarter 4 figures as detailed below:

Q1 New Birth Visit Figures (76.27% overall)			Q4 New Birth Visit Figures (68.53% overall)		
Level of Service			**Level of Service**		
Universal	93/124	75%	Universal	71/103	68.93%
UP	78/100	78%	UP	78/114	68.42%
UPP	9/12	75%	UPP	10/12	83.33%
Unknown	0/0	0%	Unknown	0/3	0%

A review of safer sleep advice given to families of newborn babies has recently been undertaken by the service and as a result new guidance and a risk assessment tool developed for practitioners across Torbay. This tool will allow practitioners to identify and support families who may have additional vulnerabilities by identifying the risk factors.

9.3 Community Dental Service

There has been some improvement in activity due to return of staff from maternity leave. Recent successful recruitment for the service will support the ongoing challenge for urgent dental care and also open courses of treatment are currently increasing.

9.4 Torbay Recovery Initiatives (Drug & Alcohol Service) (TRI)

SUCCESSFUL COMPLETIONS

1.2 Successful completions as a proportion of all in treatment

(n) = number of successful completions / all in treatment
Baseline period: Completion period: 01/04/2021 to 31/03/2022
Latest Period: Completion period: 01/04/2022 to 31/03/2023
Benchmarking comparison: Top quartile range for local comparators
Direction of travel (D.O.T): Current data measured against the baseline (B) and Last Quarter (LQ). Due to rounding small differences may not be visible in displayed percentages, but are taken into account in D.O.T. calculation.

	Baseline period		D.O.T		Latest period		Top Quartile range for Comparator LAs	Range to achieve Top Quartile
	(%)	(n)	B	LQ	(%)	(n)		
Opiate	6.5%	37 / 573	▼	▼	5.5%	31 / 559	7.68% - 11.29%	43 to 63
Non-opiate	45.9%	68 / 148	▼	▼	31.9%	45 / 141	38.21% - 52.94%	54 to 74
Alcohol	42.6%	167 / 392	▲	▲	43.2%	176 / 407	41.63% - 52.12%	170 to 212
Alcohol and non-opiate	39.2%	65 / 166	▼	▼	31.3%	57 / 182	36.80% - 62.50%	67 to 113

TRI have seen a reduction in successful completions. This data was for Quarter 4 2022-23 as this data has a time lag from OHID (Office for Health Improvement & Disparities). The service is working on a plan for improvement with next quarters data due imminently.

9.5 Maternity

Achievements

Improvements seen in the elective early pregnancy pathway with introduction of "Golden Hour" whereby women are booked into the early slot on the DC surgical list so that there is the potential for less disruption to the patient experience.

Risks & Challenges

- Obstetrics and Gynaecology capacity – ongoing service review in progress. Chief Medical Officer is to discuss outcome of job planning with Executive team. The continuing gaps have a potential impact on ability to declare CNST compliance as well as for CQC assurance.
- Potential impact of a gap in neonatal nursing workforce and subsequent impact on service provision and CNST compliance. Director of Midwifery has provided some input to Child Health matron to support the mitigation plans.
- Intelligence suggests that CQC will be concluding maternity inspections by end of calendar year – the maternity team have an action plan and have updated CQC assurance group on areas of risk.
- Continued awareness of heightened media interest in Maternity and Neonatal services and the impact on the assurance required.

9.6 Community Sexual Health Service

A new booking-in system commenced for the service which is proving more efficient in assessing patients and creating greater capacity.
A Contraception Clinic for LARC (Coils and Implants) commenced at the end of September at Brixham Hospital; this is being piloted for a 3-month period initially, to gauge demand and impact.

9.7 Healthy Lifestyles & Personalised Care

A new service specification for diabetes education commences from 1st October. Service development is underway to support the achievement of new performance metrics. This includes the development of Connect Plus for self-referrals, and a better interface with the patient record system "Halo" for reporting.

9.8 Social Care

The Torbay health and social care system is fully integrated which means there is a single planning process in place to address winter pressures, and many of the measures needed to smooth end-to-end flow during peak periods are already in place as business-as-usual to support elements of the NHS winter plan's 10 high impact interventions, particularly in relation to both reducing admission to and improving discharge from hospital. This includes measures such as:

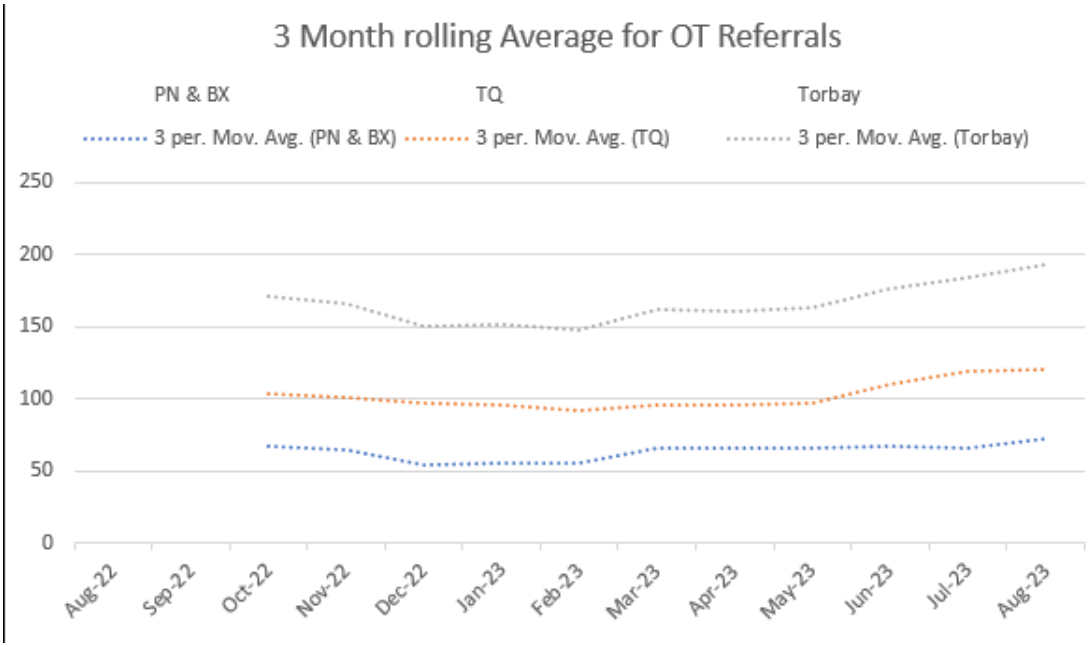
- Improvements in intermediate care provision, ensuring that older people can return home to use domiciliary care, rather than be admitted to bed-based care. This includes the development of a new 29-bed intermediate care unit and the commissioning of 17 additional reablement beds.
- More domiciliary and personal assistant services in the community, which also specialise in complex support, that people can buy directly, including with a personal budget or direct payment.
- A stronger focus on resilience, reablement, and access to aids and assistive technology.

- An adult social care 'front door' with a more effective asset-based approach to short-term and preventive help, strengthened by improvements in collaborative working with the local voluntary and community sector.

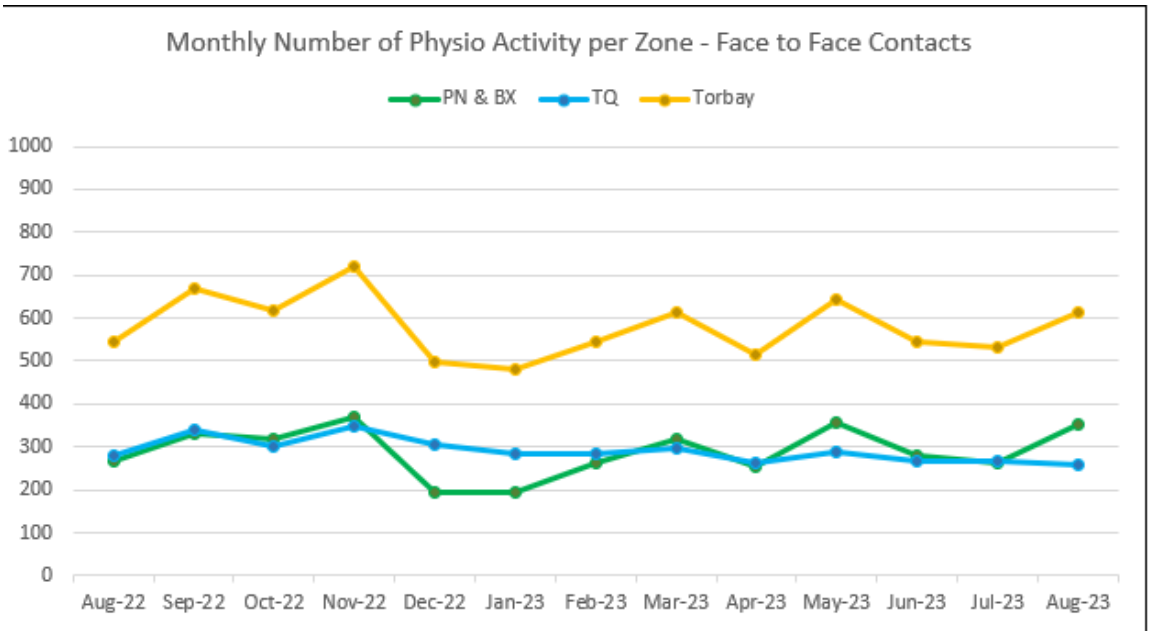
9.9 Bay Wide Community Health Services

9.9.1 Therapy

The occupational therapy (OT) waiting list is 110 in both areas with the oldest wait from June for a referral. Physiotherapy (PT) team in Torquay is 50 with a wait of three weeks and Paignton and Brixham is 59 with a 4.5 week wait. An Assistant Practitioner 0.5WTE is due to return from her placement which will assist in reducing the waiting lists.



Phyio activity

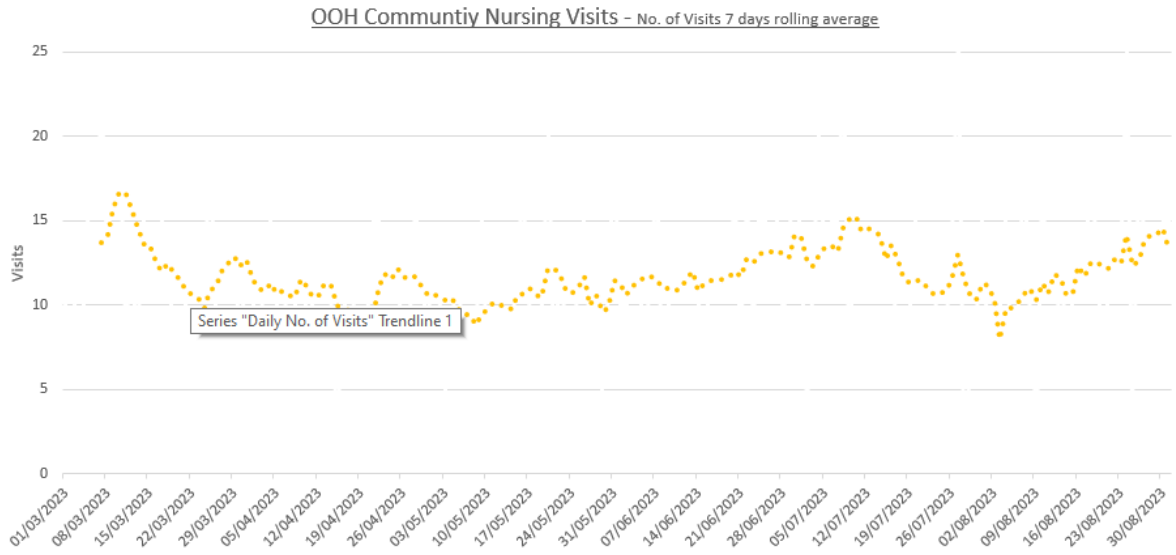


9.9.2 Community Nursing

The Torquay (TQ) community nurses (CNs) have recruited a B6 CN with an interest in diabetes to support the 50 insulin dependent diabetics that can be delegated due to their unstable presentation.

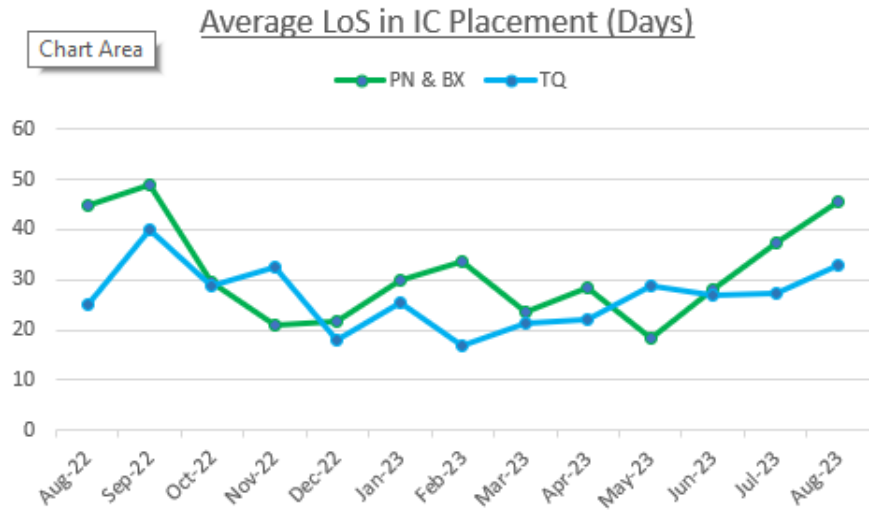
Paignton and Brixham (P&B) continue to support their new starters with training to develop community-facing skills and competencies.

The out of hours (OOH) CN team are recording the number of visits and mileage travelled so that we can reskill mix the service in line with productivity.



9.9.3 Intermediate Care

The IC teams are managing their home-based workloads well and are seeing a reduction in length of stay. 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 the IC lead in Torquay has created the opportunity to redesign and develop a Bay wide response. Currently we have 40 patients across the Bay in placement, with an average LOS of 39 days impacted by several very complex patients.



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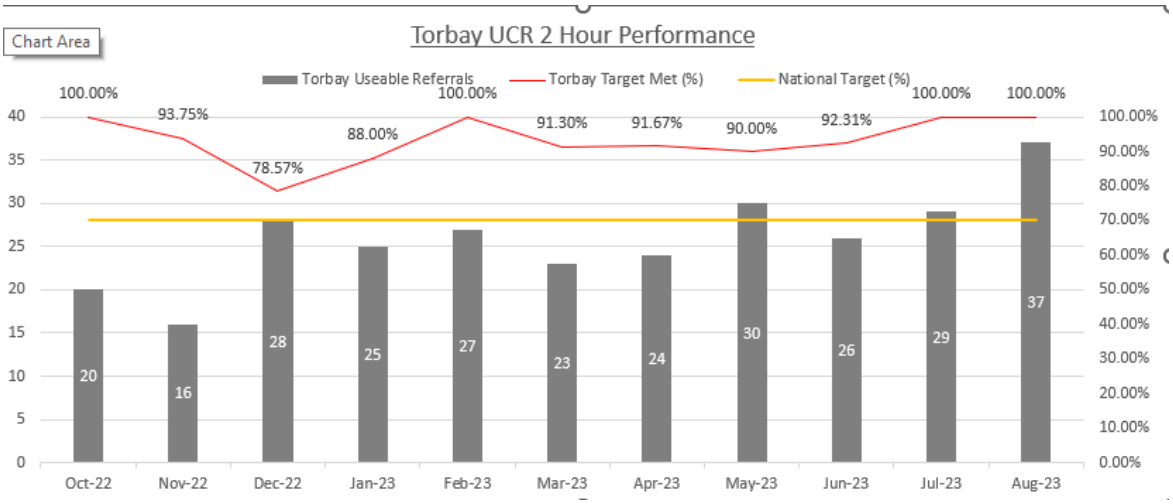
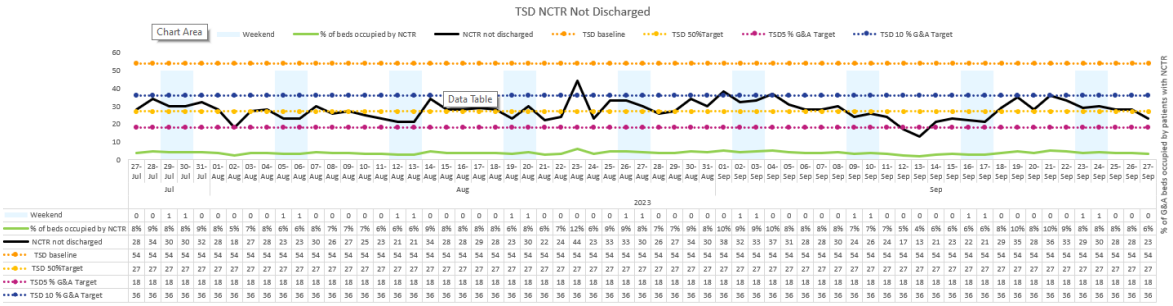
9.10 Urgent Care Response (UCR)

The teams are achieving the national target in their response times, meeting the two-hour response target, and exceeding the target for two to 48-hour response. We have achieved 100% 2hour response and increased the volume by 27% in the last month. UCR 2-48hour response is 96%



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



NCTR- has fluctuated between 5% and 10% throughout September. Currently the NCTR is 5.8%. Plans are in place to reduce to 5% or less.

- Daily review of NCTR and validate recording.
- Twice weekly meeting established this week to review the patients that have been referred for assessment by Complex Discharge Team to reduce time from referral to the team to the assessment documentation (referral form) being sent to the Discharge Hub. This will reduce the potential of deconditioning by reducing loss of bed days.
- Continue with clinicians in Discharge Hub to complete functional discharge to assess (D2A) assessments.

Pathway 1 (P1) - we have movement and good flow. Time to transfer reduced to on average to two days.

Block contract hours to support short-term service extended in Torbay until April 2024. South Devon extended until end of June 2023. Monitoring utilisation of these block hours and scheduling of workload is undertaken to maximise efficiency.

Pathway 2 (P2) - The 17 block beds in Torbay provided by the demand and capacity monies are being utilised. Senior review multidisciplinary team (MDT) review of all P2 referrals to the discharge hub is influencing positively however further improvement of the triage is required to reduce the time to transfer from seven days to five.

Mapleton in South Devon continues to provide 10 block IC beds. The LOS and onward support are being monitored and reviewed. This is being fed back through the DCC governance structures.

Pathway 3 (P3) - 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.

DCC continue to exert greater due diligence on patients requiring funding for P2 and 3. The Bed Bureau is having to contact 15 homes for each referral before requesting authorisation for funding. This has contributed to reduction in daily complex discharges.

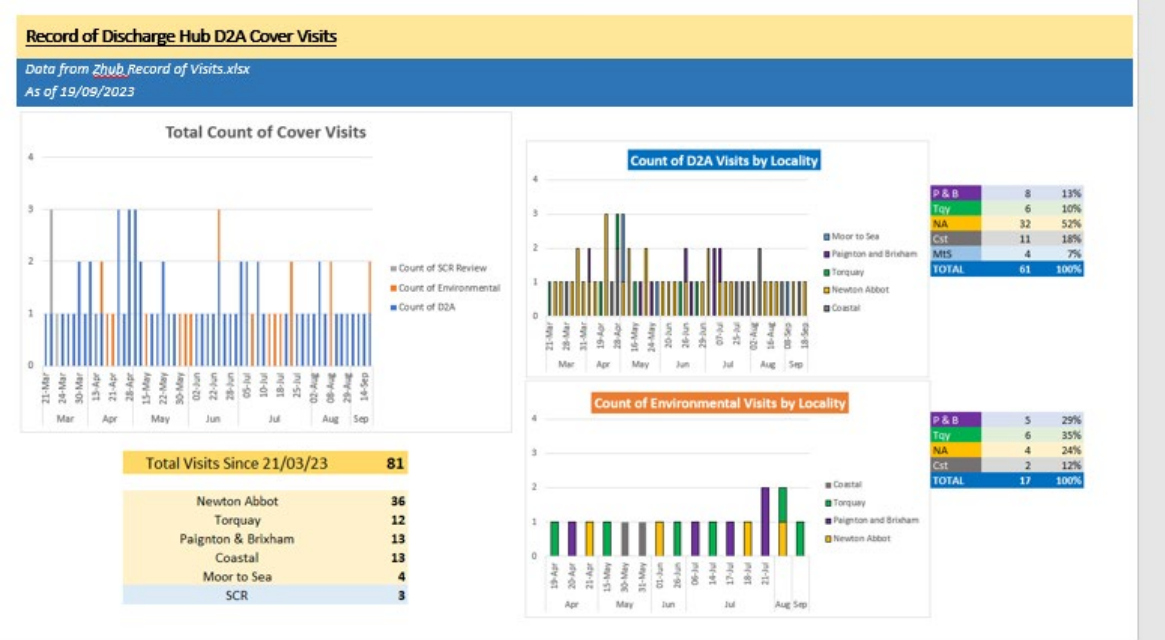
Time to transfer has increased for South Devon in September

Time to transfer (in days) per pathway, split by locality:

	South Devon	Torbay
P1	1	0
P2	9	3
P3	5	45

**Outliers in Torbay P3*

The clinicians in the discharge hub continue to complete 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. Many of these visits being completed in the Newton Abbot locality this is due to capacity in the locality. Discussed with the CSM.



9.12 Continuing Healthcare (CHC)
Torbay and South Devon CHC team are currently achieving 83% against a national target for CHC decisions made within 28 days. The target is 80%

10.0 Healthcare of Older People (HOP) and Frailty

10.1Stroke and Neuro Rehab
Sentinel stroke national audit programme (SSNAP) results have been released for Q1 2023. Once again George Earl, our hyper-acute unit, and acute pathways scored a D with very little improvement in the points allocated. Domain 1 – scanning – improved but there was a deterioration in Speech and Language Therapy (SALT) and Occupational Therapy (OT) which has seen a fluctuating picture over the last 12 months has dipped again. Despite much work being done collaboratively with the bed and site teams Domain 2 – time taken to get to and time spent of the stroke unit – remains at an E.

SALT have had significant staffing challenges due to vacancies, which have continued into Q2 with one of their more experienced band 7's going on a career break but should this improve in September with the start of new band 5 staff and the interim band 7 who came into post in July.

SSNAP Scoring Summary:	Team type	Routinely admitting team	Routinely admitting team	Routinely admitting team	Routinely admitting team
	ISDN	SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula
	Trust	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust
	Team	Torbay Hospital	Torbay Hospital	Torbay Hospital	Torbay Hospital
	Time period	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
	SSNAP level	D	D	D	D
Team-centred KI levels:					
Team-centred Domain levels:	1) Scanning	C	B	B	A
	2) Stroke unit	E	E	E	E
	3) Thrombolysis	D	D	D	D
	4) Specialist Assessments	E	E	E	E
	5) Occupational therapy	A	C	A	B
	6) Physiotherapy	C	D	D	D
	7) Speech and Language therapy	D	E	E	E
	8) MDT working	D	D	D	C
	9) Standards by discharge	A	B	A	A
	10) Discharge processes	D	B	B	B
Team-centred KI level	Team-centred Total KI level	D	D	D	D
	Team-centred Total KI score	52.0	48.0	54.0	56.0
Team-centred SSNAP level	Team-centred SSNAP level (after adjustments)	D	D	D	D
	Team-centred SSNAP score	49.4	48.0	54.0	56.0

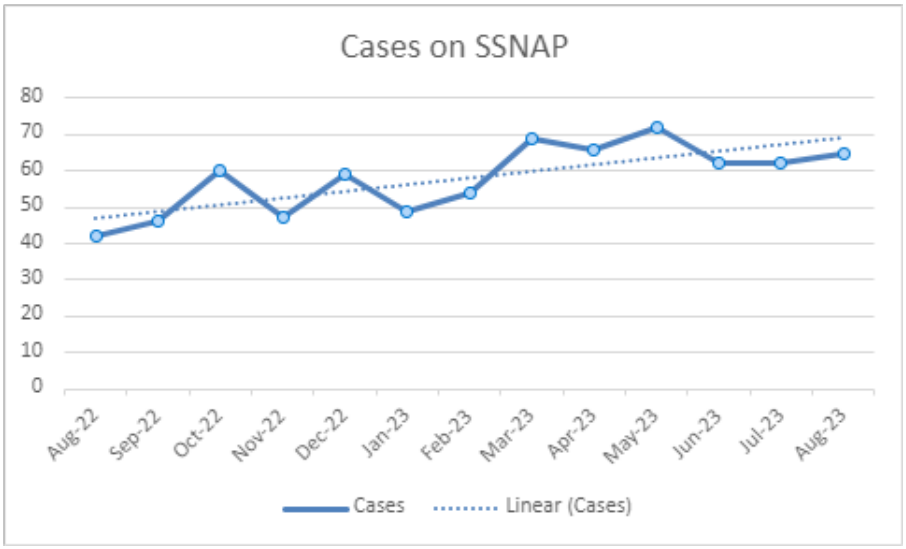
Time critical Stroke Standards	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Number of patients (N)	42	33	46	32	39	34	41	42	56	56	59	60
% Scanned within 1 hour	40.5	45.5	45.7	57.8	48.7	61.8	41.5	57.1	50.9	65.5	59.3	53.3
% Scanned within 12 hours	88.1	93.9	93.5	93.3	92.3	94.1	95.1	100	92.7	98.2	91.5	96.7
% 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	26.3	21.1
% of patients spending 90% of their time on the Stroke Unit	64.1	54.8	60	76.7	37.1	54.5	70.7	70.7	63	80	61.4	69.5
% (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)	11.9 (7)	6.9 (4)
% Received Thrombolysis within 1 hr	25	20	50	100	0	50	0	50	50	0	42.9	75
SSNAP		A	B	C	D	E						

The Q4 team results for Templar ward saw the team score a D, predominantly due to their audit compliance i.e., the inputting of their SSNAP data to the National database. Templar results for Q1 improved to a C but disappointingly their audit compliance remained at an E. This is also due to staffing challenges. Progress has been slow in the recruitment process for a band 4 SSNAP administrator but the job description is with agenda for change for matching. This will not represent an increase in staffing numbers but is a refresh of an existing post. This post will provide continuity and a dedicated focus to SSNAP but most importantly will mean band 6 and 7 therapy and nursing staff will be released back to clinical care.

Templar also saw a deterioration in their SALT performance for the same reasons identified above and sadly standards by discharge which will require further investigation.

SSNAP Scoring Summary:	Team type		Non-acute inpatient team	Non-acute inpatient team	Non-acute inpatient team
	ISDN		SW Peninsula	SW Peninsula	SW Peninsula
	Trust		Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust
	Team		Newton Abbot Hospital	Newton Abbot Hospital	Newton Abbot Hospital
	Time period	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
	SSNAP level		D	D	C
Team-centred KI levels:					
Team-centred Domain levels:	1) Scanning		N/A	N/A	N/A
	2) Stroke unit		A	A	A
	3) Thrombolysis		N/A	N/A	N/A
	4) Specialist Assessments		N/A	N/A	N/A
	5) Occupational therapy		C	A	A
	6) Physiotherapy		A	A	A
	7) Speech and Language therapy		C	C	D
	8) MDT working		N/A	N/A	N/A
	9) Standards by discharge		A	B	D
	10) Discharge processes		A	A	A
Team-centred KI level	Team-centred Total KI level		A	A	B
	Team-centred Total KI score		86.7	90.0	80.0
Team-centred SSNAP level	Team-centred SSNAP level (after adjustments)		C	C	C
	Team-centred SSNAP score		62.6	61.2	60.8

As reported in previous months, current performance is reported via the SSNAP DIY tool which does not correlate fully with the full DIY tool. A recent refresh of DIY tool runs for the past 12 months showed that the number of stroke admissions over the last 12 months was higher than previously reported. This only affects what we have reported locally – it does not impact our national reporting as different time windows are used for submission of data. Additionally, whilst the actual numbers we have reported for our time critical standards have changed the overarching "story" has not. The data refresh shows an increasing trend in stroke admissions over the last 12 months.



The time critical standards show that we continue to struggle with access to the stroke unit.

Time critical Stroke Standards													
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Number of patients (N)	42	46	60	47	59	49	54	69	66	72	62	62	65
% Scanned within 1 hour	40.5	39.1	46.7	57.4	44.1	57.1	44.4	53.6	50	59.7	58.1	51.6	55.4
% Scanned within 12 hours	88.1	93.5	88.3	93.6	91.5	89.8	92.6	95.7	90.9	97.2	90.3	95.2	92.3
% Admitted to Stroke Unit within 4 hours	25	17.4	8.8	27.3	0	14.9	15.1	29.9	23.1	28.2	25	20.3	27
% of patients spending 90% of their time on the Stroke Unit	65	53.3	59.3	76.1	41.1	61.7	68.5	71	61.5	77.8	59.7	70.5	69.8
% (No.) Patients that received Thrombolysis	9.5 (4)	10.9 (5)	10.2 (6)	11.1 (5)	6.9 (4)	10.4 (5)	7.7 (4)	10.4 (7)	9.4 (6)	8.3 (6)	11.5 (7)	6.7 (4)	3.1 (2)
% Received Thrombolysis within 1 hr	25	20	50	100	25	60	0	57.1	50	16.7	42.9	75	0
SSNAP		A	B	C	D	E							

Our local Stroke Integrated Stroke Delivery Network is keen to support us to be part of the Thrombolysis in Acute Stroke Collaborative (TASC). This national network has been set up with the support of NHS Elect to drive improvement in thrombolysis rates nationally. The NHS Plan set out an ambition for 20% of patients suffering a stroke to receive thrombolysis; currently the national average is about 11.5% and Torbay sit short of this at about 9.4%. Whilst not an outlier regionally the ISDN feel that Torbay would have most to gain by being part of TASC. Membership would require significant commitment including the requirement for dedicated performance and project management support. Discussions are ongoing to understand whether this level of support is available.

11.0 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Report of the Director of Transformation and Partnerships			Meeting date: 25th October 2023
Report appendix:			
Report sponsor:	Deputy CEO/Director of Transformation and Partnerships		
Report author:	Deputy CEO/Director of Transformation and Partnerships		
Report provenance:			
Description/Purpose of the report and key issues for consideration/decision:	The Transformation and Partnerships Directorate provides a wide range of strategic planning and enabling functions to deliver the Trust strategic ambitions. This paper outlines the progress against key strategic objectives over the last quarter. The paper outlines significant progress being made across the Directorate, notably in the following key areas: • Submission of the BBF site enabling case alongside a significant level of master-planning for the new hospital development • Development of collaborative partnerships through the fragile services workstream across the acute provider collaborative • Providing transformation support for clinical and operational teams in elective care through the GIRFT Further Faster Programme • Improving our internal communications channels and developing our model of engagement with our teams in line with our compassionate leadership approach • Local Care Partnership approach to improving community engagement in health and wellbeing services • Developing our approach to local purchasing as an anchor institution		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Trust Board is asked to note the report of the Directorate of Transformation and Partnerships		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The Transformation and Partnership Directorate is a strategic enabling function and works with teams across the whole organisation and wider system.		
How does the report support the Triple Aim:	The report outlines the Directorate has a direct responsibility for working with partners to improve population health management and there is significant work taking place to support the reduction in health inequalities and community wealth building. The report outlines enabling work that supports of clinical and operational teams within the organisation and across the system to improve the quality and sustainability of services.		

Relevant BAF Objective(s):	Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	
External standards affected by this report and associated risks	

Report title: Report of the Directorate of Transformation and Partnerships		**Meeting date:** 25th October 2023
Report sponsor	Deputy CEO/Director of Transformation and Partnerships	
Report author	Deputy CEO / Director of Transformation and Partnerships	

1. Introduction

The Directorate of Transformation and Partnerships has a forward-facing portfolio that includes a range of strategic enabling functions. The functions support clinical and operational teams across the whole organisation and beyond, working together with public and private sector organisations locally, regionally and nationally to enable us to fulfil our purpose and support people in Torbay and South Devon to live well. The Building a Brighter Future (BBF) Committee now provides oversight and Board assurance of the work of all of the teams within the directorate.

This report describes some of the key recent highlights from the teams within the Directorate.

2. Supporting people to live well in our communities through our local strategic partnerships

The Board of Directors received the review of the progress against our organisational Strategy in September 2023. Strategically our commitment to supporting our community to live well is underpinned through our commitment to effective partnership working with our local communities and maximising our contribution to the prosperity of our local communities in our role as an anchor organisation.

As part of our Local Care Partnership (LCP) we have worked with colleagues in Healthwatch and Torbay Council and community and voluntary partners across South Devon to set up a group to develop effective relationships with local people and involve them in the design of health and care services, as well as improving the efficiency and effectiveness of LCP engagement activities.

This work builds on successful community development and engagement pilots in Torbay, that has particularly focussed on those in the most deprived areas. In advance of the group's inaugural meeting we held a meeting with members of the public to explore themes of involvement and people's relationships with their health and care services relationships. This has highlighted the diversity of people's preferences and will help us tailor the early stages of the group's work plan accordingly.

Alongside Devon system partners we have worked with Healthwatch to understand the experiences of people accessing urgent and emergency care with the report due to be published shortly. This is a follow up piece of work to engagement we did in 2021/2.

As an anchor organisation, within coastal and rural communities with high levels of deprivation and frailty, supporting our contribution to the wider determinants of health is a critical enabler of supporting our local people to live well. We signed our memorandum of understanding for our local Community Wealth Building Partnership in 2022 and our partnerships manager has pioneered the development of a dataset that

measures our spending patterns and how this identifies opportunities that retain and expand our NHS spending power within local communities.

Community Wealth Building is seeking to develop deep rooted economic benefits for the Torbay and South Devon community, including boosting local growth, jobs, better skills, drive education attainment, strong innovation, more resilient institutions and a stronger pride in place, whilst also presenting shorter-term financial opportunities.

At this stage the Trust are testing several practical ideas that will make a meaningful difference and we are primarily working alongside the directorates of Finance, Procurement, Workforce, Education and Workplace on the journey. Key activities include:

- Working with partners in the transition to a “local economy” (shorter, more resilient supply chains).
- Working with the Trust Resourcing Hub & DWP to bring those furthest from the jobs market into meaningful employment.
- Working with the Trust's Education and Workforce Directorates to explore the opportunities to boost the number of entry levels jobs fulfilled by a "grow your own" pathway.
- Increasing the awareness of Community Wealth Building value and benefits with many public, commercial and third sector partners across the ICB footprint.
- Facilitating a summit on the 23 November 2023: "Unlocking Local Economic Potential: Why it matters"

Our health inequalities lead has supported a freephone number has been set up for use in the maternity unit, to support pregnant women who experience concerns to seek immediate support and triage. Evidence from other parts of the country suggest that women may have access to phones but no credit to make the calls, therefore reducing the barrier of a paid for call will enable women and pregnant people to receive timely support and advice when they need it. Further work is underway to codesign promotional materials with a socially diverse range of women and pregnant people to ensure people are aware of the service and how they can access it.

We are actively engaged as a partner in Torbay’s Health and Housing program, using data and evidence to target those at greatest risk of poor health (focussing on those living with respiratory conditions and cardiovascular disease) and aligned to the first three targets in the Devon ICS Joint Forward Plan 2023.

Building on the work of our coastal engagement group (representatives from health, housing, education, VSCE sector groups, Teignmouth and Dawlish hospital league of friends and patient representatives in the Teignmouth and Dawlish areas), we have established a dedicated community stakeholder group with community representatives to agree how we will involve local people in discussions around the future use of the Teignmouth hospital site. Two meetings have taken place to date (in July and October) and we have also responded to a number of questions members have raised about the consultation which took place in 2020 and the proposed new health and wellbeing centre for Teignmouth which secured planning permission in June 2023.

We are establishing two new children and young people forums to amplify the voices of children, young people and their families and carers in relation to our services. We will be working with VCSE partner organisations to deliver the forums and are now progressing through the relevant procurement processes.

Through our Torbay and South Devon NHS Charity we are working closely with local fundraisers and organisations to support people to live well. The monies raised improve the experience and environment for patients, carers and staff across our acute, community and adult social care services. We are deeply indebted to our dedicated hospital Leagues of Friends, the Torbay Medical Research Fund, the Torbay Prostate Support Association and all the other charities who raise money and provide us with funds to support our work.

Our annual review of our fundraising activities for 2022-23 was published last month and is available here and we recently launched a Facebook page for our charity which can be viewed here.

In recent months local fundraisers have:

- raised £2,900 for our special care baby unit to create a new wellbeing area for parents, including a hot drinks machine
- raised over £1,000 for our emergency department in memory of Ben
- started a 1,000 mile cycle challenge to raise £10,000 for our breast care unit by cycling from Lands End to John O'Groats
- taken part in one of the world's toughest Ironman events in memory of their father and raised £1,000 for The Lodge
- undertaken a sky dive, 25km walk and many more activities to raise funds for Templer ward at Newton Abbot.

A new fund has become available (the NHS Charities Together greener communities fund) which is offering grants of up to £300,000. We have submitted an expression of interest for a joint project between ourselves and Devon Wildlife Fund to increase biodiversity and community engagement. If successful this project will support our green plan to improve our sustainability as well as creating a healthier and pleasanter environment for our people and communities, supporting them to live well.

3. Providing excellent care in partnership with local provider organisations

We are an active member in leading collaborative partnerships across a range of services with other local providers. Our directorate provides a range of support for clinical, operational and corporate teams to deliver better services, experience and outcomes for patients, reduce waiting times and improve quality and efficiency through greater collaboration.

Across the Peninsula our acute trusts are supported to work collaboratively where there are areas of fragility and through the One Devon elective care pilot. Our directorate team has supported a strengthening in partnerships between clinical and operational colleagues in a number of services to reduce waiting times and improve access to specialist care.

Our improvement and innovation team have embraced work with the national Getting It Right First Time Further Faster programme (GIRFT FF). Led by our clinical and

operational teams, the directorate provide co-ordination and change/project management capacity to deliver rapid service improvements, leading to reduction in waiting times for local people. Our focus over recent weeks has been in supporting the improvements in ophthalmology, cardiology and orthopaedics.

Our team have initiated work in a codesigned campaign to improve young people's mental health and wellbeing digital therapeutics, providing project management and support to this Devon wide work. This work is bringing together stakeholders from across Devon to create and test a digital campaign that supports young people to identify and better self-manage a range of mental health and wellbeing concerns, utilising evidence based digital therapeutic apps and highlighting other local support opportunities for young people to consider.

Working alongside a wide range of people including young people will help ensure that the campaign has wide support, is effective and supports young people in a manner and in ways that makes sense and adds value to them.

4. Informing, involving and responding to our people

Our engagement and communications strategy, approved by our Board of Directors in September 2021, describes our strategic intention to move away from a broadcast style communications transmission approach to building trust and developing real engagement with our people, communities and teams through meaningful conversations.

Our intent is to embed a step change in our relationship with our people, enabling a mindset shift to build success and change the way we do things around here (facilitating improvement through meaningful conversations). This will support the delivering not only of our operational plan but crucially our enabling plans for our organisational strategy (most notably our people promise plan, quality plan (including PSIRF), improvement and innovation plan and our communications and engagement strategy). Earlier this year we launched a series of conversations with our teams and to date more than 130 conversations have taken place which have, on the whole, been very well received and we are now moving into phase two of our engagement plan as we seek to build better relationships with our teams.

Aligned to our conversations, we have developed a simple methodology to support our people to adopt an outward mindset and become change and innovation leaders which includes:

- uplifting positive psychology master classes available to all teams, at their request
- monthly mastermind groups supporting positive psychology in to action
- training of interested people to deliver master classes and support mastermind groups
- 28-day challenge groups with monthly show, tell and celebrate sessions.

We will also ensure academic evaluation to evidence impact on staff, patients, service users and our organisation.

A test of change took place with our professional services (enabling functions) including the people directorate, improvement and innovation team, education directorate and workplace team on 02 August 2023. A further test of change workshop took place with a group of clinical managers from across the organisation. The feedback and insights

from both tests of change are directly informing the compassionate leadership programme that we launched at the end of September as well as the Board development agenda.

5. Trust-wide improvement and innovation progress

Our improvement and innovation team work alongside the trust clinical and operational teams to improve our clinical pathways. Within the Urgent & Emergency Care portfolio, the frailty virtual ward has recently gone live and is being supported by IC Community teams, MAAT and Acute Frailty, demonstrating the power in collaboration. This is the first frailty virtual ward that is focusing on step up (i.e. admission avoidance) rather than step down and is 100% community based. The Frailty Acute Intervention Team have redesigned their model from bed based to SDEC, which will ensure best use of their skillset, ensuring they are seeing the right patients at the right time, and avoid admissions. The improvement team are holding a 90-day celebration event to assess the early outcomes of this new model.

Within the Planned Care portfolio, significant progress has been made within Ophthalmology with Exeter Nightingale providing additional diagnostic slots for Glaucoma to support a reduction in our backlog. We will have 40 slots starting in late October which will ensure our backlog of >1k will be reduced to 0 within 16 weeks. The Outpatient Space Utilisation Group has been delivered and the business case for a new room booking system has been approved, alongside changes to the PAS system to improve reporting of Patient Initiated Follow Up (PIFU).

Within the Workforce & People Promise Portfolio, the Organisational Reshaping of the Trust was successfully launched and plans are in place for annual reviews. A Culture of Inclusion plan has been created and is currently being rolled out to support cultural shift within the Organisation. The Compassionate Leadership Framework has been created and signed off by the executive team. The framework is currently being embedded into a number of the Trust processes, e.g. learning and development, accountability, progression and retention, recruitment and onboarding via training and facilitated workshops with People Directorate colleagues.

Within the Child Health Transformation Portfolio, an SSPAU improvement project team has been initiated, working with key stakeholders (e.g. labs, porters, IT) to streamline processes on the unit and support UEC flow across the system. A plan is under development to create extra cubicle space and extra OP clinic space. Improvement work has been progressing at pace with the paediatric specialist nurses for neonatal care, eating disorders, discharge, allergies and epilepsy. Pathways have been developed and published, signposting information has been circulated across the community and digital training content has been recorded and publicised. A ward clerk competencies framework has been developed and there is a buddy system in place for new starters. Team development sessions have been held for medical secretaries and typing assistants.

Within the Quality & Patient Safety Portfolio:

- Falls programme has achieved a sustained >60% of patients assessed for lying and standing blood pressure supported by training over 370 ward staff and a new vision assessment tool within the new PCRAB booklet. This will enable a single consistent vision assessment as part of the fall-safe bundle. Hot Debriefs,

aligned with PSIRF, have been launched which take place within the same shift as the fall ensuring they are reviewed quickly and effectively.
- Nutrition & Hydration Programme is working with Formic to combine the 5-a-day tool with safety assessments into one electronic system. Verbal feedback to staff from the CQC recognised marked improvements to Nutrition and Hydration.
- 90 static Quality Boards are now in place across the Trust for teams to use as quality improvement tools, with a digital board being trialled for remote teams.
- Patient Experience of Discharge programme has launched a single discharge checklist to be used as part of the PCRAB booklet and telephone surveys are being undertaken monthly to ensure current patient voice is heard and an improved 'experience of discharge' dashboard is available on DCIQ.
- The new Sepsis Trust wide policy will be sent for ratification at the end of October. Hive sepsis training compliance is currently at 53% since its launch in August.
- The Deteriorating Patient programme has supported an increase of over 40% in NEWS2 training compliance since January, alongside an increase in numbers of observations recorded at the time of admission or initial assessment.
- Within the PSIRF programme, plans are in place to support delivery of the new policy and plan by April 2024. Implementing DCIQ ensures we are now LfPSE compliant and will enable greater triangulation, transparency and integration of data for learning and improvement. PSII training was procured and delivered to key staff such as ADNPP's and Clinical Governance Coordinators, with Executive Oversight training scheduled for March 2024 and plans in place for future training supported by the Quality Education Framework.

Within the Building Capability programme, 26 staff graduated from the 4-day Improvement and Innovation Practitioner Programme at our first celebration café.

In order to support and be aligned to the local and national strategic direction the In-sites team have undertaken an ongoing mapping exercise to identify opportunities and support with business intelligence. A funding agreement has been agreed between the Trust and Healthwatch for ring fenced In-Sites funds to support stakeholder engagement. This funding will support co-design with our population and recognises the ongoing value that stakeholder partners bring to developing and testing innovation. The first of these engagements involved Torbay Youth Trust who supported the development of our Little Journey pathway, with suggestions made by the young people implemented into the pathway and operational plans.

6. Delivering our digital ambitions within our health and care strategy

Our health informatics service and strategic digital team are maximising the opportunity offered by significant levels of investment, from the National Frontline Digitisation Programme, to underpin the transformation of our clinical pathways across acute and community services, using digital technologies as an enabler.

Our Board of Directors receives regular updates on the delivery of Electronic Patient Record (EPR) business case, procurement and implementation readiness. The team are preparing our clinical and operational workforce to embrace a digital first approach to the delivery of healthcare, ensuring that where appropriate more people are able to access their services remotely, within their homes and communities. This will enable us

to invest more time and resource with those who are not able to access digital methods of delivery and require greater levels of co-ordinated, personalised face to face care.

Our Health Informatics Team are working in partnership with Devon Partnership Trust (DTP) to support the provision of an integrated electronic patient record for our Child and Family Health Devon service. This is an important enabler for the transformation of community services for local children and we are extremely grateful to our colleagues in DPT for their leadership of this exciting and important improvement in services.

The opportunity of digital transformation is underpinning the next iteration of our health and care strategy, which will be presented in early draft form to our Strategy Group in October 2023. The BBF Committee will provide oversight and assurance of the development of the health and care strategy to the Board of Directors.

7. Investing in our infrastructure

The BBF infrastructure team have worked tirelessly to secure investment within our local community infrastructure, which includes the successful Board approval of the Torbay Hospital site-enabling case, which is the foundational first step of our new hospital development.

A successful partnership arrangement with In-Health will provide a Community Diagnostic Centre for local people in Torquay which is due to open in April 2024.

The BBF Committee had the opportunity to review recent draft master-planning option appraisals for the design of the new hospital of our acute site. This work is critical to underpin the final design of the provision of a separate elective care facility for the people of Devon, building on our national reputation as an exemplar site for day-case and short-stay surgery as well as the delivery of a new emergency care facility and a new ward block that will re-provide our ward beds into a modern facility to future proof care for local people.

8. Conclusions

The Directorate of Transformation and Partnerships have played a significant role in the strategic development of partnerships that will underpin the transformation of our acute and community services. Alongside this the team have secured significant strategic investment support from the national team to ensure that our estate and digital infrastructure is modernised and supports the delivery of our health and care strategy ambitions.

9. Recommendations

The Trust Board are requested to receive and note the Directorate of Transformation and Partnership report.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's report			Meeting date: 25th October 2023
Report appendix:			
Report sponsor:	Chief Executive		
Report author:	Associate Director of Communications and Partnerships		
Report provenance:	Reviewed by Executive Team 17 October 2023		
Description/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:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board are asked to receive and note the Chief Executive's report.		

Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides the Board of Directors Board with narrative information on key corporate matters as well as local, system and national initiatives and developments that contribute to our vision and purpose.
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System
Risk: Risk ID: *As appropriate*	
External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Report title: Chief Executive's report		Meeting date: 25th October 2023
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our vision and purpose

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

2 Our strategic goals and our priorities

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

Our strategic goals are:

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

Our priorities are:

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

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

3 Our key issues and developments

Key issues and developments to bring to the attention of the Board since the last Board of Directors' meeting held on 27 September July 2023 are as follows:

3.1 Excellent population health and wellbeing

Preparing for winter – flu and COVID-19 vaccination programme for our people

Our annual flu and COVID-19 vaccination programme for our staff, volunteers and most vulnerable patients is well underway. To date just over 35% of our substantive staff and nearly 15% of our bank staff have received their vaccinations.

Annual members' meeting

The recording of our Annual Members Meeting which took place on 23 September 2023 is now online. You can view it here and also watch our 'Our year, your Trust 2023' video which celebrates our achievements during a challenging year.

Support and awareness group set up for male breast cancer

Male breast cancer isn't a condition that is widely spoken about, but around 370 men are diagnosed with the condition each year in the UK. Our breast cancer and Macmillan psycho-oncology team met in September to hold the UK's first face-to-face moving on

group for men who have been diagnosed, treated or recovered from breast cancer.

The group is supported by members of the breast care team and a Macmillan counsellor to inspire men to get checked if they have any concerns and to offer a space where they can talk about their experiences and their ideas and commitment to raise awareness of breast cancer in men.

Wards decorated yellow to raise awareness of young people's mental health
On world mental health day (10 October), many of our teams wore yellow to support Young Mind's #HelloYellow campaign and raise awareness of young people's mental health. Areas were decked in yellow to highlight our dedication to support young people and our desire to improve their experiences.

Colleagues in our emergency department showcased some of the paediatric emergency team's great improvement work to ensure care for children and young people is focused and personalised. This included turbo teaching and how resources, information and raising awareness has positively impacted on people's experience of the service.

Celebrating black history month
Black history month 2023 is a momentous occasion to recognise and celebrate the invaluable contributions of black people to British society. This year's theme, called 'saluting our sisters', pays homage to the crucial role black women have played in shaping history, inspiring change and building communities when their contributions have been ignored, their ideas appropriated, and voices silenced.

Events included online sessions with the South West's medical director for system improvement and professional standards, Kheelna Bavalia, Kerrie Montoute, programme management lead, Jenni Douglas Todd, chair of Dorset's integrated care board and Dionne Korsah, head of programmes for staff engagement, health and wellbeing to learn about the region's inclusion strategy and what it means for our staff.

In partnership with our trade union colleagues at Unison we held a celebration evening on Tuesday 24 October to salute all our ethnic minority sisters and brothers. It was a great evening where we got to share stories of success, challenge and personal achievement while enjoying fantastic food.

NHS schools prize giving
I was delighted to be asked to present a prize to Emma Jamin from Ivybridge Community College by colleagues at Health Education England earlier this month. Emma is the regional winner for the south west of the schools careers competition called Step into the NHS. Emma created creative and succinct poster for the role of paramedic. The competition aims to raise young people's career aspirations and awareness of over 350 careers in the NHS. It was a privilege to meet Emma and her peers and answer some of their questions about working in the NHS.

International visit
We are proud to be hosting a return visit from colleagues at SingHealth (Singapore). Last September 11 representatives from SingHealth spent two days with us as part of their international study trip researching integrated care, population health and financial drivers.

Their focus is on our model of integrated care, our experiences and learning from developing our model, how we adapted it during the pandemic and our further developments and future plans. Their interest is very much in taking our learning and experiences to help them respond to similar challenges in Singapore.

We are grateful to our teams who are hosting our visitors and sharing their experiences and learning. We hope to continue to share and learn from each other in the future.

3.2 Excellent experience receiving and providing care

Current pressures
Over the past month we have seen a rise in infection control challenges which has affected patient flow. This is set against a further backdrop of industrial action throughout October.

For the sixth consecutive month our urgent and emergency care performance was above 60%. While our performance is behind our trajectory for the national oversight framework (NOF) 4 recovery target of 72% it remained steady at 68.42%.

We have achieved the Faster Diagnosis Standard consistently since February 2023. Our work to reduce the number of people waiting for cancer treatment over 62 days continues and accordingly to the latest figures we are in the top 30 high performing trusts nationally in this area, second in the south west region and the best in Devon.

Our performance in planned care services has remained strong. We have robust plans in place to have no one waiting more than 65-weeks by 31 March 2024 but these are coming under increasing pressure from continued industrial action. Plans to mitigate this position are under review and this work will take place with the involvement of our partners to ensure Devon wide solutions can be explored for our most ‘at risk’ services.

Our community urgent care response teams are achieving the national target in their response times, meeting the two-hour response target, and exceeding the target for two to 48-hour response.

Continuing industrial action
We continue to manage the impact of the ongoing industrial action involving a number of trade unions as part of their dispute with the government over pay and conditions.

During October we managed action involving our junior doctors, consultants and radiographers and we continue to minimise disruption as best as we can.

These are not disputes between our organisation and our people, and we hope an agreement will be reached as soon as possible.

Specialty and specialist doctors recognised at awards ceremony
We celebrated our specialty, specialist and associate specialist (SAS) doctors at our first dedicated SAS doctors’ awards on 12 October at The Imperial Hotel in Torquay. People could nominate a SAS doctor who they felt had gone over and above to provide better health and care, and it was lovely hearing their stories. Our inaugural winners are:

- Learning, research and development: Shyam Singham
- Patient safety and quality improvement: Atanu Sengupta

- Making a difference (leadership and management): Sony Augustine
- Innovation and service development: Karina McKearney
- Respect, teaching and training: Simon Barnes
- SAS doctor of the year: Simon Barnes
- Special commendations: Maree Wright and Louise Webster.

Simon Barnes, who won SAS doctor of the year award, has been put forward as a finalist in the Chair's Special Award category of the Our People Awards, our staff recognition awards.

The awards were funded by NHS England, and organised by SAS doctors, colleagues who support this staff group and medical education teams, led by Dr Niki Burke, associate specialist in emergency medicine and SAS tutor and advocate. Niki was instrumental in organising the event to champion the profession and supporting our SAS colleagues to develop and take on new opportunities and I would like to formally thank her on behalf of the Board for her dedication and commitment.

It starts with me: creating a safe and compassionate place to work
Our people priority is to ensure our people feel safe and supported at work. We want to create a healthy and supportive culture at work, where people are civil towards each other and feel confident to speak out if they see or hear something that could cause harm. We want them to know they will be supported and not blamed when things don't go as we would like. This will ensure we deliver our vision of better care for all.

We ran a series of staff engagement sessions at the start of the year to co-design our plans with our people. They told us there was an absence of compassionate leadership – specifically listening and acting upon what we hear. It's important we have a consistent approach to leadership, and we know people's experiences are different across our teams – a gap which has widened since 2020.

We are working hard to create an environment at work where everyone feels safe, healthy and supported, but to achieve this we need to have a consistent approach to leadership.

In October we launched our new compassionate leadership framework to help build a healthy culture at work where our people feel safe, supported and confident to speak out. To help us achieve our goal, we have introduced training for all leaders and managers, starting with band 7 colleagues and above to help their teams feel valued and supported. Furthermore, we are improving our equality, diversity and inclusion training to help us to embed an inclusive culture within our organisation.

Colleagues from our people team are visiting our sites to talk to people about what's important to them at work to help us improve what we do. We will make sure people's views and the experiences they have shared with us are considered and included in our compassionate leadership framework.

Congratulations to our newly appointed chief nurse research fellows
Abdul-Manan Alhassan and Lucy Yarnold have been appointed as this year's chief nurse research fellows.

The award will allow them both to spend one day a fortnight working on their service improvement research project, spending time with the clinical research delivery team to find out more about how trials work and provide opportunities for academic mentorship.

Abdul is a nurse at Dawlish Community Hospital and the research project he will be taking forward this year will be to investigate the factors that influence retention of internationally educated nurses.

Lucy is an ultrasonographer and will explore the patient experience of the ultrasound service.

Celebrating our allied health professionals
We celebrated the achievements of our allied health professionals (AHPs) during October as part of the sixth annual AHP day.

AHPs are the third-largest clinical workforce within health and care and are the unsung heroes of the NHS. We employ around 650 AHPs who are focused on prevention and the improvement of health and wellbeing.

There are 14 roles that make up AHPs across our health and care pathway, from urgent care and theatres, rehabilitation, recovery and the management of long-term conditions, including podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, paramedics, physiotherapists, radiographers, speech and language therapists, and prosthetists and orthotists.

Some of our AHPs worked with our communications and digital horizons teams to create a series of videos that we shared online to celebrate their profession, and directed people to our AHP vacancies.

We launched our new AHP award to help us celebrate the work and achievements of our AHP colleagues and hope to announce our first winners by the end of the year.

Baby loss awareness week
Baby loss awareness week serves as a poignant reminder of the importance of compassion, empathy, and support for people whose babies have died.

Our chaplaincy team included baby loss awareness week in their morning prayers and with our bereavement midwife hosted a short time to remember in the chapel, with laminated prayers and poems available for people.

Anyone who has been affected by the loss of a baby can contact www.sands.org.uk and www.miscarriageassociation.org.uk who offer support to those recently and long ago bereaved.

Congratulations to our latest PRIMROSE award winner
Our latest PRIMROSE award winner is Louise Evans, health care support worker in our intermediate care team at Newton Abbot. Louise was nominated by a colleague for always keeping her patients' needs at the centre of her interventions and care. She is an asset to the team, is focused, faultlessly professional, intuitive, and extremely hardworking

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.

Ward accreditations
Three of our wards underwent accreditation in the last month. Cromie ward maintained their bronze award while Dunlop ward maintained their silver award. Cheetham Hill achieved a silver award (an improvement on their previous bronze award).

3.3 Excellent value and sustainability

Delivering best value for people in Devon
We are working in very challenging times, and Devon's entire health and care system was placed in segment 4 of the NHS operating framework (NOF4) due to its performance and financial challenges.

Our performance has improved significantly and this is due to the tremendous work taking place across clinical, operational and corporate services, working with our improvement and innovation team to make sustainable improvements. We are maintaining our improvement trajectory for both cancer and planned care despite the challenges we face – although our improvement trajectory for 78 week waits has been adversely affected by continuing industrial action. We are aiming to be back on plan against this trajectory in due course.

The Devon system continues to be in Tier 1 monitoring for urgent and emergency care performance and we have weekly meetings with regional senior staff to discuss our progress and provide assurance that we are continuing with our plans and actions to exit Tier 1 as soon as we can. All the plans for exiting Tier 1 are focussed on creating safe and calm hospitals.

Financial performance continues to be a challenge. Our forecast for the financial year shows we are at risk of not meeting our planned deficit. We continue to develop our plans with our people, and as a system to work together to reduce cost pressures and overspend to deliver savings before the end of the financial year which have minimal impact on the safe delivery of patient care or negatively affect our ability to reduce waiting times.

We are asking our people to challenge and question what we spend to help us develop our detailed financial recovery plans and have put a number of processes in place to ensure that we are delivering best value for our people and our communities.

Recruitment to our executive leadership team
Recruitment continues for our new Chief Finance Officer and Chief Medical Officer. We hope to be in a position shortly to announce our new Chief Medical Officer.

Chief Nurse to take up new post closer to home
Our chief nurse, Deborah Kelly, joined us at the height of the COVID-19 pandemic in August 2020, and during the past three years she has led us through a time of great challenge and change.

Deborah was clear when she joined us that she wanted to stay with us for three years, and it is with sadness that we can confirm that she is leaving us at the end of the year to

begin a new role with Croydon Health Services NHS Trust as its chief nurse. While we will miss Deborah's passion to nursing and her and commitment to improving the lives of the people we serve, we know she will bring the same level of rigour and enthusiasm to her new role in south London.

The Non-Executive Nominations and Remuneration committee will confirm arrangements for the recruitment of a successor.

Long serving non-executive director
Jacqueline Lyttle, who has served as a non-executive director with us for nine years, concluded her term in post at the end of September 2023. We are deeply grateful to have benefited from Jacqui's leadership, compassion and dedication for many years and wish her all the best for her future endeavours.

Opening our new multi-million-pound radiotherapy planning CT scanner suite
It was a pleasure to attend the ribbon-cutting for our new £2.8million radiotherapy planning CT scanner suite last week, alongside colleagues from our oncology services, our lead governor, members of our league of friends, and local media.

Radiotherapy plays an important role in treating, curing, and controlling cancer, and we know that beginning a course of radiotherapy can be an unsettling and worrying time. We hope our new suite will provide a better environment for people and help them to approach their treatment with confidence.

The speed at which the unit has been built, and our new CT scanner installed has been phenomenal to watch. The modular units were built off-site and lifted into place at Torbay Hospital. The site behind Hengrave House has been a hive of activity during the past seven months, and using modular buildings has allowed us to complete the build six months quicker than if this was a traditional build. I would like to formally thank everyone who has been involved with delivering this exciting project on time, including our capital development team and our cancer treatment teams who do incredible work to care for and treat our patients.

I would also like to formally thank Torbay Hospital's League of Friends on behalf of the Board for its continued generosity and donation of £590,000 to purchase our new state of the art Radiotherapy Computed Tomography (RT-CT) scanner which will provide images faster and more efficiently, and support our radiotherapy service to plan radiotherapy treatment for people with cancer. This will enhance the high quality of care our staff provide to our community. We are grateful to have such a dedicated league of friends for whom we rely upon to fund such vital and much-needed equipment to help us care for our patients.

Our fundraising annual review
Our annual review of our fundraising activities for 2022-23 was published last month and is available here and we recently launched a Facebook page for our charity which can be viewed here.

Breast care unit supporter sees equipment bought in memory of his wife
We were delighted to welcome supporter Mike Waters to our breast care unit earlier this month to see a new doppler and headlamp that were funded by donations made to our charity in memory of his late wife, Marilyn.

Marilyn's legacy will help the team on the unit to offer better care and support to people, particularly those requiring breast reconstruction surgery. We are grateful to Marilyn's friends and family for their kindness and generosity in supporting the unit.

Torquay United players for fundraising for Torbay Hospital
Torquay United AFC's Jack Collins and Lewis Stobbs brought smiles to the faces of some of our youngest patients this month when they visited children on Louisa Cary ward.

The players visited the children's ward to meet patients and see the ward's new carbon dioxide monitor, which was funded by generous donations made by the club's staff, players and fans.

4. Chief executive engagement October

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
• Staffside • Freedom to Speak Up Guardian • BAME representative • Radiotherapy scanner ribbon cutting • Long Service Awards • SAS awards and celebration event • Trauma and orthopaedics directorate meeting • League of Friends' bingo	• Chief Executive, University Hospital Plymouth • Interim Chief Executive Officer, Royal Devon University Healthcare • Medical Director, Royal Devon University Healthcare • Chief Finance Officer/interim Chief Executive Officer, Devon Partnership Trust • Director of Adult Social Services, Torbay Council • NHS schools prize presentation.

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System for Devon (ICSD)

The Peninsula Acute Provider Collaborative's immediate focus

In May 2023 a new Chair was appointed to the PAPC on a 12-month fixed term contract: Stephanie Elsy, currently Chair of NHSE Bath and Northeast Somerset, Swindon & Wiltshire ICB. The PAPC is maturing and is in the process of reviewing its scope so that it is well placed to address the challenges ahead. Given the context and

respective priorities of NHS Devon and NHS Cornwall and Isle of Scilly, the Peninsula Acute Provider Collaborative in intend to:

- prioritise fragile services where patient access needs to be improved and we need ensure that we have right workforce in the right place to deliver good quality care. Currently we are targeting the following fragile services: Urology, Interventional Radiology, Stroke, Histopathology, Microbiology and Oncology. A service is determined to be “fragile” against an agreed set of access, quality, safety, and workforce criteria. Given these criteria, we anticipate that more services will be added to this initial list for immediate attention to ensure their ongoing stability
- look at opportunities for improving productivity and performance by working towards the delivery of single services across the full portfolio of our sites by ensuring we make the best use of our building infrastructure, technology, and transport services
- agree which services need to be transformed. We will involve and engage with patients, the public and our workforce to identify and agree new service models and design a programme and supporting plans which align with other programmes and plans being developed within the wider Devon, Cornwall and Isles of Scilly integrated care context, for example, primary care, mental health, social care and community services
- involve and engage with our stakeholders. We want to hear the ideas of our teams on how our services and processes could be improved. We want to be open and honest about what is happening and why and so we will be working and engaging with local people, our staff and our partners to explain more about the challenges we face and how we are rising to them.

We will provide regular reports to Acute Trust Boards on the work programme, progress and achievements of the Peninsula Acute Provider Collaborative.

6 Local media update

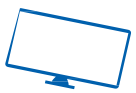
6.1 News release and campaign highlights include:

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

Key media releases and responses

League of Friends seafront bed push
celebrating our fantastic Torbay Hospital League of Friends who collected more than £1,000 by pushing a hospital bed around Torquay seafront



Fundraisers thanked for supporting people undergoing chemotherapy
a cream tea was held to thank some of the people and groups who helped raise enough money to purchase new scalp cooling machines for people undergoing chemotherapy on Ricky Grant Day Unit

Devon NHS braced for double strike action, expected to be ‘most difficult yet’
a plea to our community to support the NHS during the industrial

Creating an impactful and effective charity
A new customer relationship management tool, called Donorfy, is now in place to provide detailed and accurate reporting and measurement of the charity's work.

New charity materials have been produced including collection items, printed materials and clothing.

We created our new charity Facebook to raise awareness of our work.

We published our charity report Our Year, Your Fundraising 2022-2023

Digital engagement

	Linkedin	Facebook	X (Twitter)
Followers (as of 30 September)	6,776 +176	4,184 +128	7,964 +2
Engagement	367	1,903	285
Impressions/ reach	18,371	176,715	13,086
Best performing post	If you have visited Torbay Hospital recently you will have seen the progress we have made expanding our endoscopy unit. Last month our contractors and teams worked really hard to support the crane lift part of the project. The expansion will provide a fourth endoscopy room, helping the department meet increasing demand and reduce the time people are waiting. 3,100 impressions 103 reactions 1 repost	It was so lovely to be able to celebrate with our fantastic supporters as Ricky Grant Day Unit held a cream tea event for some of our fundraisers. Thanks to their generous support, the unit purchased two new scalp cooling machines for people undergoing chemotherapy. Find out more 👉 https://ow.ly/HoRh50PKbik 7,754 impressions 237 reactions 12 shares	IConsultants in Devon are set to strike from the 19-20 September and junior doctors are set to strike from 20-22 September. NHS services across the county are preparing for double the impact with both groups due to strike together for the first time on 20 September. Local people are being encouraged to use services wisely over the four days of industrial action to help the NHS cope with the challenging period ahead. Find out more on our website 1,105 impressions 5 likes 2 reposts

Website activity

59,856 unique views of our website (the number of people viewing our web pages)

180,943 total views of our web pages (including people revisting the same page)

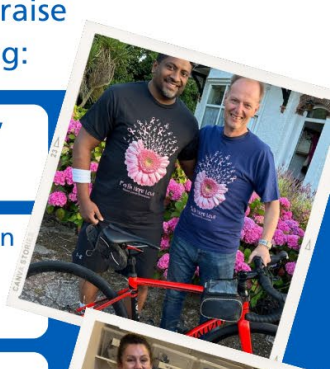
Most popular pages:

- vacancies (22k views)
- MIU waiting times (18k views)
- homepage (13k views)
- physio appointment times (7k views)
- visiting times (3k views)

Fundraising

Torbay+ South Devon NHS Charity

There has been lots of activity during September to raise awareness of, and donations to our charity, including:



Two supporters cycled 1000 miles from Lands' End to John O' Groats to raise £10,000 for the breast care unit.

A supporter took part in one of the world's toughest Ironman events in memory of her dad and to raise £1,000 for The Lodge.

Following Torquay Rotary's donation of £1,000, six young adult carers set sail on a tall ships voyage from Portsmouth to Plymouth, gaining valuable new skills and experiences.

A thank you cream tea was held on Ricky Grant Day Unit for 20 fundraisers who had raised £30,000 to fund two new scalp cooling machines, to help reduce hair loss during chemotherapy. The machines replaced the previous equipment which was over ten years old and not well used due to not being always reliable.

A young supporter raised £1,000 by doing a skydive for Louisa Cary ward, following her time there as a patient five years ago.

Thanks to donations in memory of a patient, a doppler and headlamp were purchased for the breast care unit

The final project of the stage 1 NHS Charities Together funding for a kitchen on Louisa Cary has been completed. Work now starts on the projects funded by the stage 3 grants, including an outside decking area for Louisa Cary.

An expression of interest was submitted to the NHS Charities Together greener communities fund to support a joint project with the Devon Wildlife Fund to increase biodiversity and community engagement.

Engagement

We had meaningful conversations with around 100 people from our community and partner organisations during September to listen to people's experiences and ideas about how we can improve our services, including:

- coastal engagement group meeting
- Teignmouth Hospital stakeholder group meeting
- Children and Family Health Devon participation board
- our annual members meeting, including an engagement stall and attendee survey, completed by 22 people, to inform our event planning for next year
- special care baby unit staff presentation on engagement to introduce benefits and provide an update on new engagement approaches. The presentation was also recorded for people unable to attend
- our survey to redesign adult social care webpages in partnership with Torbay Council has been completed by 27 people who use our services
- progression through procurement processes to create two new children and young people forums to amplify the voices of children, young people and their families and carers.

Recruitment

We launched our new social media campaign to promote volunteering and to encourage people to sign up as a volunteer. Each Thursday we will focus on the range of volunteering opportunity people can get involved with.

Our Facebook and Instagram recruitment adverts to promote our theatre roles to support the new theatres build reached 17,130 people and resulted in 743 job advert visits.

We will be evaluating the success of the advert to understand how many people applied for the role and were successful in being invited to interview as a result of our adverts.

Accessibility
At least one in five people in the UK have a long-term illness, impairment or disability. Many more have a temporary disability. This includes those with:

- impaired vision
- motor difficulties
- cognitive impairments or learning disabilities
- deafness or impaired hearing.

In September 2018 the government introduced accessibility regulations for all public sector organisations to ensure anything published on websites and mobile apps is accessible. This includes making sure our designs are clear and simple and that we support people who have specific communication needs. For example, someone with impaired vision might use a screen reader (software that lets a user navigate a website and read out the content), braille display or screen magnifier. Or someone with motor difficulties might use a special mouse, speech recognition software or on-screen keyboard emulator.

It is important that our website is easy to use on a mobile, does not contain PDFs that cannot be read out on screen readers, and poor colour choices are used on designs that make text difficult to read – especially for visually impaired people.

The average reading age in the UK is also nine years. We need to use words that people can understand, and try not to use complicated words, including medical language, without explaining to people what they mean. This is really important when talking to people about their health to make sure they understand important instructions and diagnosis.

The accessibility regulations say that websites and mobile apps must be made accessible and must include an accessibility statement. As well as being the right thing to do, we may also be breaking the law if our website and mobile apps do not meet accessibility requirements.

In April 2023 the Cabinet Office carried out a review of our website and said some areas of our website were not accessible. We were given a month to fix these issues, which we have now done and continue to check and repair any issues using a number of free tools, including reports by accessibility tool checkers Silktide and Reachdeck. The Cabinet Office confirmed it was satisfied with the changes we made.

We are using a free version of Silktide reporting which provides a limited overview of our work, but it has rated our website as 79% accessible. Our aim is to increase this score during the next 12 months as part of a wider programme to make sure all communications (including board papers and patient letters) are accessible and that we use plain English in our written work.

This includes a new piece of work to identify which teams and people are responsible for web pages to review the content on their pages, ensure they’re up to date and accessible.

7 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR) M6 2023/24 (September 2023 data)			Meeting date: 25 October 2023
Report appendix:	Appendix 1: IPR Month 6 2023/24 Focus Report Appendix 2: IPR Month 6 2023/24 Dashboard of Key Metrics		
Report sponsor:	Chief Finance Officer		
Report author:	Executive Directors		
Report provenance:	Finance, Performance, and Digital Committee Executive Directors		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • review evidence of overall delivery, against national and local standard and targets; • interrogate areas of risk and plans for mitigation; • provide assurance to the Board that the Trust is on track to deliver the standards required by the NHS Operating Framework and steps taken to satisfied NOF exit Criteria. Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to receive and note the documents and evidence presented.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The report highlights performance against the delivery of care for the people of Torbay and South Devon.		
How does the report support the Triple Aim:	*1*) population health and wellbeing *2)* quality of services provided *3)* sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 5 - Operations and Performance Standards		
Risk: Risk ID: *As appropriate*	This report reflects the following corporate risks: • failure to achieve key performance standards. • inability to recruit/retain staff in sufficient number/quality to maintain service provision. • failure to achieve financial plan.		

External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Report title: Integrated Performance Report (IPR) M6 2023/24 (September 2023 data)		**Meeting date:** 25 October 2023
Report sponsor	Chief Finance Officer	
Report author	Executive Directors	

Introduction

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

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.

The report highlights areas of risk that have been escalated through governance meetings and System Care Group Directors against National Oversight Framework (NOF) and performance metrics agreed with executive leads.

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

The Trust remains in NOF 4 being the highest level of national performance oversight. The Focus Report gives greater detail against the agreed NOF 4 exit criteria where these are not being met.

The People Committee provides governance and oversight for workforce and the Quality Assurance Committee for quality and safety metrics.

Quality Headlines

Incidents
In September 2023, 1 incident of severe harm were reported onto the national StEIS (Strategic Executive Information system). The incident was a patient fall resulting in displaced fractured of the hip. The incident is being investigated as per the national reporting framework.

Infection, Prevention, and Control
There has been a decrease in the number of bed days lost due to bed closures (232 days). An action plan has been completed with the Infection, Prevention, and Control team which includes a focus on cleaning measures, patient flow, and use of gloves and Personal Protective Equipment.

Stroke Quality Metrics

The percentage of patients who spent more than 90% of their stay on the stroke ward is a slightly improved position from August 2023 at 73%. The proportion of patients who were admitted to the Stroke Unit with 4 hours of admission is comparable with last month at 20% being below the standard of 100% within 4 hours.

Several of the domains within the SSNAP metrics from Domain 4 – 10 are meeting the expected target for care however Domains 2 and 3 remain red. (Access to the stroke ward and the amount of time spent on a stroke ward) are not meeting the expected standard. During the recent CQC inspection access to a stroke ward was noted and this improvement plan will be a focus for the organisation over the next few months.

Safer Staffing

The Registered Nurse fill rate for days during September was 98.1% which is a slight increase in August fill rate of 97.9 % and for night duty reported as 90.1% which is an increase on the previous months fill rate of 88.7%.
The fill rate for Health care support workers for days during September was 103.8% which is an increase on August fill rate of 101.5% For night duty reported as 117.3% which is a decrease on the previous months fill rate of 119.9%
The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

Workforce Headlines

Progress in delivering the workforce implications of the 2023/24 Operational Plan

The Trusts substantive workforce is 63 Whole Time Equivalent (WTE) over plan in September 2023, worsening from the previously reported 29 WTE above plan in August. Areas of growth since August have been seen in the Nursing and Midwifery staff group showing an increase of 20 WTE, also the Support to Clinical Staff group which includes Support Workers have increased by 12 WTE.

Local workforce factors affecting NOF4 exit criteria and mitigating actions

Workforce is one of the key factors affecting specialties that are challenged in delivering Referral to Treatment (RTT) performance targets. Substantive clinical and consultant vacancies are seen across several of the most challenged areas of ENT, Urology, Gynaecology, Colorectal, and Neurology. A number of actions are being taken in mitigation, these include the development of marketing materials, workforce modelling, and collaborating with other Trusts.

Overview of workforce metrics

The turnover and sickness rates for September are lower than those forecasted in the operational plan.

Mandatory Training has shown a steady upward trend in overall compliance over the last 12 months. Compliance has decreased slightly by 0.38% in September to **91.59%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **78%** and Information Governance at **87%.**

Whilst improving marginally each month since February, we remain challenged around Achievement Review compliance at 78% against the target of 90%. Visibility of this data at cost centre level, as well as through Care Group and assurance meetings, remains in place to support improvement plans.

Performance Headlines

The Chief Operating Officer Report provides oversight against key Care Group performance. Performance exceptions are included against areas not meeting the National Oversight Framework (NOF) exit criteria indicators.

As a Trust we remain in Tier 1 (highest level of performance oversight) for Planned Care and Urgent and Emergency Care. The Chief Operating Officer meets weekly to review recovery action plans and performance against trajectories with NHS England.

National Oversight Framework 4 exit criteria

Urgent and Emergency Care (UEC) NOF 4 headlines
The Trust is meeting one of the UEC NOF 4 exit criteria, this being the performance trajectory for the percentage of inpatients with No Criteria to Reside (NCTR).

- Ambulance handover time lost increased in September reporting 2579 hours lost waiting over 15 minutes (from 1707 hours lost in August); this does not meet the trajectory of 1137 hours.
- The percentage of patients waiting over 3 hours for an ambulance handover increased to 14.7% from 6.5% in August.
- The Trust's Urgent and Emergency Care (UEC) 4-hour performance improved achieving 68.4% but did not meet the September trajectory of 72%.
- Operational focus remains on improving the discharges earlier in the day. 21.5% of discharges were achieved before noon against the 33% target.
- The Trust has continued to meet the trajectory for the percentage of beds occupied with No Criteria To Reside with 7.4% of occupied beds against the trajectory of 7.5%.

Elective Recovery NOF 4 headlines

Elective Referral to Treatment (RTT)
Elective recovery against the NOF 4 exit criteria is ahead of trajectories for 6 of the 7 exit indicators. The trajectory to reduce the number of patients waiting over 78 weeks for treatment was not met with 187 reported against the trajectory of 111. The cumulative impact of industrial action has been a main factor impacting this performance. The impact of further industrial action is a future risk being assessed with an expected impact on long-wait trajectories. The Trust continues to provide oversight and mitigations of industrial action through the Industrial Action Patient Safety Committee.

Cancer standards

The Trust is meeting the Faster Diagnosis Performance and 62-day backlog position against the exit criteria target. Torbay is no longer included in Tier 1 performance oversight for cancer standards.

Finance headlines

As at Month 6, the Trust reported an adverse financial variance to plan of **£2.398m**. This is primarily driven by the net impact of the ongoing Industrial Actions. **£1.638m** relates to the net cost implication and **£0.760m** for potential Elective Recovery Fund (ERF) clawback due to activity delivery being lower than planned.

At this stage of the year, we have identified **£32.3m** risk to forecast outturn (please see details on slide 17 of the 'Monthly Performance Report'). Mitigating action are currently being worked up to minimise the forecast risks.

Against our in-year CIP target of **£46.58m**, the number of schemes, currently showing as green and having plans in place for delivery is totalling **£36.6m** FYE. Against the £36.6m green schemes (through governance and in/ready for delivery) we are currently reporting a confirmed delivery of **£23.52m**, of which **£19.63m** (83%) being Recurrent schemes. YTD we are currently delivering a positive £2.5m vs plan.

Please also note that the YTD impact of Industrial Actions has been reported to the Integrated Care Board (ICB) and NHS England and Improvement (NHSE/I) as required.

Our current cash balance as at 31st September is £19.2m which £3.3m higher than planned which reflects the lower than planned spend of capital. Our cumulative revenue PDC drawn down is c£17m which is still within our YTD deficit allowance.

Capital-related cashflow is **£11.8m** adverse, largely due to the pay down of the capital creditor **£8.7m** during the beginning of the year. PDC capital drawdown is **£5.7m** behind plan partly due to in year capital expenditure beng **£3.9m** behind plan.

Debtor movement is **£6.2m** favourable, which is principally due to the 22/23 retrospective pay award **£12.1m** not being included in the initial cash plan. This is partly offset with an increase in ASC debtors.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

October 2023: reporting period September 2023 (Month 6)

Working with you, for you

National Oversight Framework - Introduction

NHS Torbay and South Devon NHS Foundation Trust

NHS National Oversight Framework

In December 2022 NHS England rated the Trust at SOF level 4 for financial and operational performance along with the wider Devon System. The levels are rated as levels 1 to 4 with NOF 4 being the highest level of oversight. This decision was reached due to our financial performance and delivery against planned care and urgent care performance targets.

Exiting NOF 4 is the key objective to achieve over the coming months and measured against a set of exit criteria for key performance measures, based on the Operational Planning Guidance for 2023/24.

The performance section of the IPR (Integrated Performance Report) focuses on progress against the NOF 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.

Operational performance updates are described in the Chief Operating Officer's report.

System NOF governance and reporting – System Improvement and Assurance Group (SIAG)

Monthly meetings are in place to review system progress and Trust level reports against NOF exit criteria. This meeting is attended by all provider Chief Executive Officers and Integrated Care System leads.

Tier 1 performance oversight:

The Trust remains in the Tier 1 (the highest level of oversight) performance regime from NHS England against Referral to Treatment (RTT) long waits and against Urgent and Emergency Care performance.

The Trust attends weekly executive meetings with the Southwest region performance leads to review progress and gain assurance on agreed action plans to exit Tier 1.

National Oversight Framework 4 Exit Criteria – Indicative Measures

Torbay and South Devon NHS Foundation Trust

The set of exit criteria below will be used to monitor the Trusts performance levels required to exit NOF 4.

Each indicative measure has a target to be achieved to exit NOF 4 with local trajectories 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 NOF 4 exit plans, and progress against these plans and milestones, as they are agreed.

Exit Criteria Measures

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

National 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 NOF 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) Trust Management Group (TMG)	Improving	
Ambulance handovers greater than 15 minutes	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	
Over 12-hour visit time; and ED (type 1) 4-hour target	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	
Increase in pre-noon patient discharges	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	Improving	
Reduction in 'No criteria to reside'	SCGD – Families community and place based	Deputy Medical Director	Chief Operating Officer	ORG TMG	Yes	No
Patient wait over 104 weeks and 78 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	No	Yes
Patient wait over 65 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes
75% of GP referred patients diagnosed within 28 days	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes
Cancer longer than 62-day wait	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes

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

Torbay and South Devon NHS Foundation Trust

Matters of concern/key risks to escalate	Major actions commissioned/work underway
• Future Industrial Action. • TIFF Theatre delivery of activity, recruitment of workforce. • Infection outbreaks impacting on staff and bed availability. • Medical workforce gaps and the availability of locums to support. • ED demand rises. • Medical engagement in adoption of changes to ward rounding to improve the timeliness of discharges. • Speed of delivery for changes to Portal to allow common view of potential discharges over the weekend. • Capacity of transformation team support to improvement plans.	• ECIST support to Frailty pathway. • Establishing a further x4 cubicles in ED to support Ambulance Offloads. • Operational 'drum-beat' bed meetings process changing to streamline Directorate information gathering. • Review of Transformation support for improvement plans and review of audit of wards to increase medical engagement. • Discussions arranged for development of 'Emergency Village'.
Positive assurances	**Decisions made**
• Planned care performance achievement is above trajectory. • 62-day cancer backlog is 28th best in England. • UEC 4hr performance above 60% for sixth month in a row and continuing to rise month on month. Performance ranked nationally at 60th out of 119 (104th in October 2022) • NCTR performance is best in Southwest. • Management of Industrial Action becoming business as usual with established playbooks. • PTL meeting governance and performance management assurance complete by Michael Wilson's team. • Winter Plan reviewed by Michael Wilson's team. • GIRFT review of UEC processes complete.	• Ongoing transition of space and process changes within ED for non-admitted patient performance improvement. • Weekend plans to focus on Friday handover medical and nursing meeting information. • IT prioritisation of Portal. • Winter Plan agreed. • Review of Pathway 1-3 processes report completed and under review.

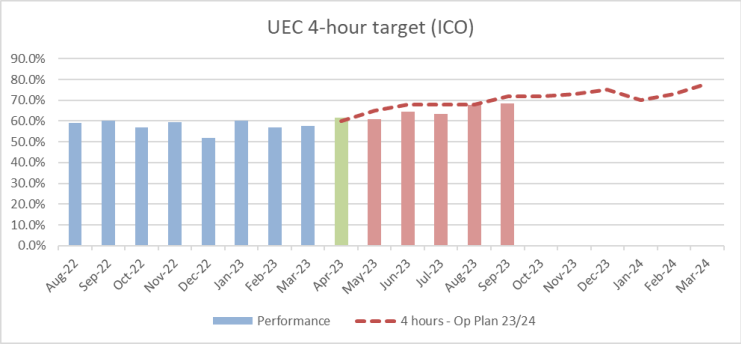
National Oversight Framework (NOF) 4 Exit Criteria – Urgent and Emergency Care Performance Summary

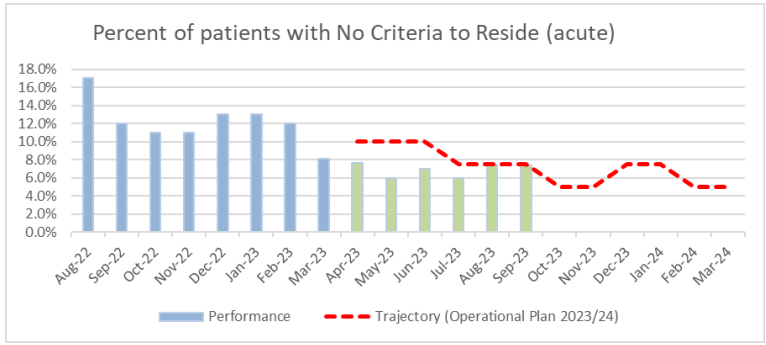
Torbay and South Devon NHS Foundation Trust

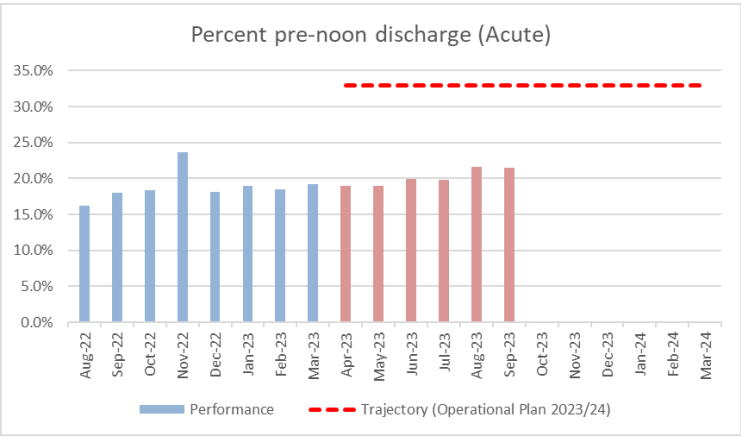
	Target March 2024	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Operational Plan trajectory Sept 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2844	3512	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	1137
Percentage of Ambulance handovers greater than 3 hours		23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	No trajectory
Total average time in ED (hours/minutes)		07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	No trajectory
ED attendances where visit time over 12 hours	0	906	988	939	1207	823	599	977	568	893	797	637	794	686	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	72%
% patient discharges pre-noon	33%		18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	12.0%	11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	7.5%

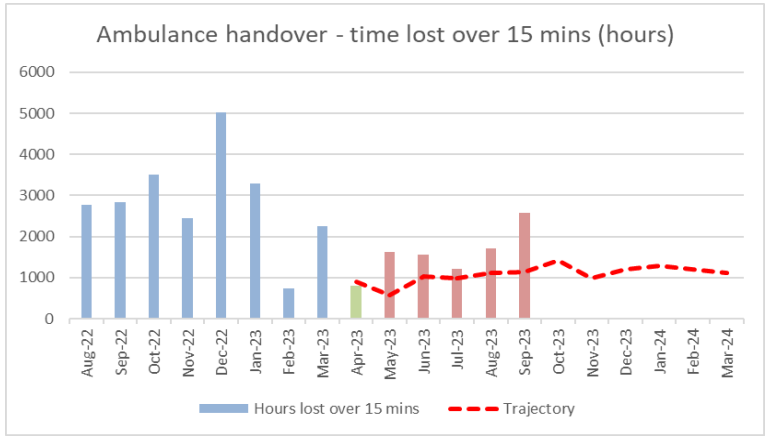
Trajectories have been agreed as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

2023/24 RAG indicator
- Meeting monthly trajectory
- Not meeting monthly trajectory









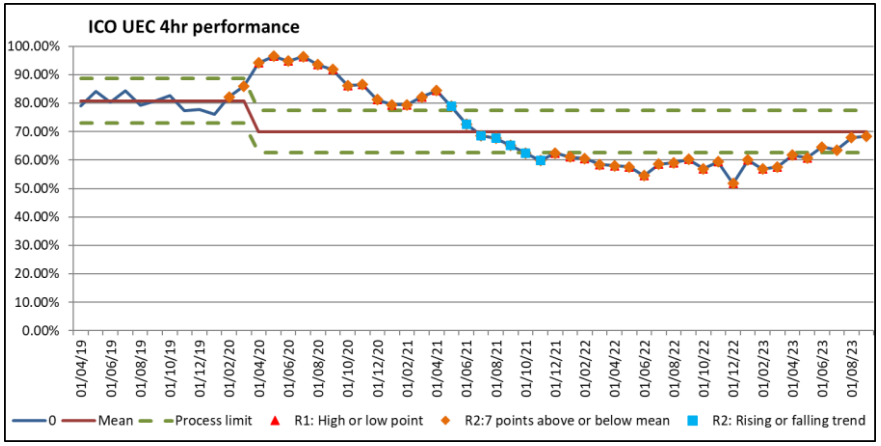
Exception report: 4-hour ED target: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

ED Type 1 performance 54.3%
ICO Performance 68.4%

This is a 10.3% improvement compared to October 2022 for type 1 and 20% improvement for the ICO.



Operational update

- September recorded a reduction in the average time in ED with 5h 46m compared to 6h 5m for August, and 7h 33m for September 2022.
- Type 1 performance - overall attendances increased from 5589 in September 2022 to 6594 in September 2023; an 18% increase in attendance. We achieved 54.3% against our ED 4-hour target, the second consecutive month the Trust has been over 50% since July 2021.
- Type 3 demand (UTC and MIU) no change from 3054 in September 2022 to 3043 in September 2023. We achieved 99% against our Type 3 4-hour target.
- Overall, our UEC performance across the ICO was 68.4%, the sixth month in succession above 60% and the second consecutive month above 67% since August 2021.

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:

- Confirmation of Same Day Emergency Care (SDEC), JETS, Frailty and Acute Medical Unit Level 2 configuration to support Emergency Department escalation bed reconfiguration to support the non-admitted pathway.
- Virtual Ward – rapid expansion of pathways and volume.
- Urgent Treatment Centre (UTC) / Minor Injury Unit (MIU) stability and plans to open Dawlish.

Risks/issues

- Further infection issues
- Further Consultant industrial action
- Combination of the above

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

Torbay and South Devon NHS Foundation Trust

Performance

The number of ambulance handover delays over 15 minutes increased in September with 1828 over 15 minutes.

The hours lost due to ambulance delays over 15 minutes increased in September with 2579 hours compared to 1707 in August.

Average time lost to ambulance handover delays (hours per day)

Rolling 30-day position as at **04 October 2023**

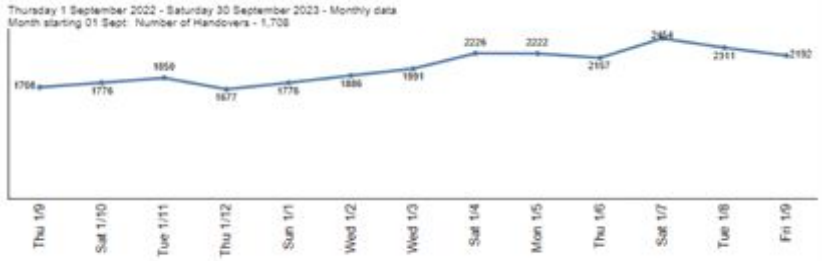
click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Derriford Hospital	214:16:56
South Western	Gloucestershire Royal Hospital	122:04:48
South Western	The Great Western Hospital	92:37:02
South Western	Royal Cornwall Hospital (treliske)	90:02:32
South Western	Torbay Hospital	84:29:16
South Western	Royal Devon & Exeter Hospital (w..	57:50:14
South Western	Royal United Hospital	37:58:56
South Western	Poole Hospital	25:24:09
South Western	Southmead Hospital	24:38:33
South Western	Bristol Royal Infirmary	24:20:17
South Western	Royal Bournemouth Hospital	20:47:46
South Western	Musgrove Park Hospital	16:04:58
South Western	Salisbury Health Care NHS Trust	10:28:35
South Western	Weston General Hospital	6:36:52
South Western	North Devon District Hospital	6:10:31

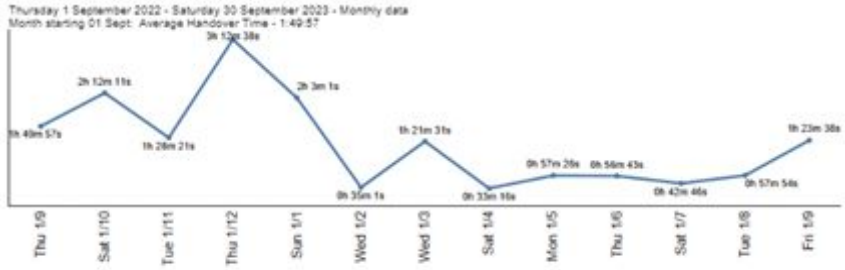
Operational update

In September, the Trust saw an increase in handover delays.

Ambulance Handover demand has risen 28% comparing September 2022 (1708) to September 2023 (2192) handovers.



The average time lost per ambulance to handover has increased from 57 minutes in August to 1hr 23min (including the 15 mins) in September 2023. This remains an improvement from average time lost in September 2022 of 1hr 49 mins.



Actions to complete next month

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

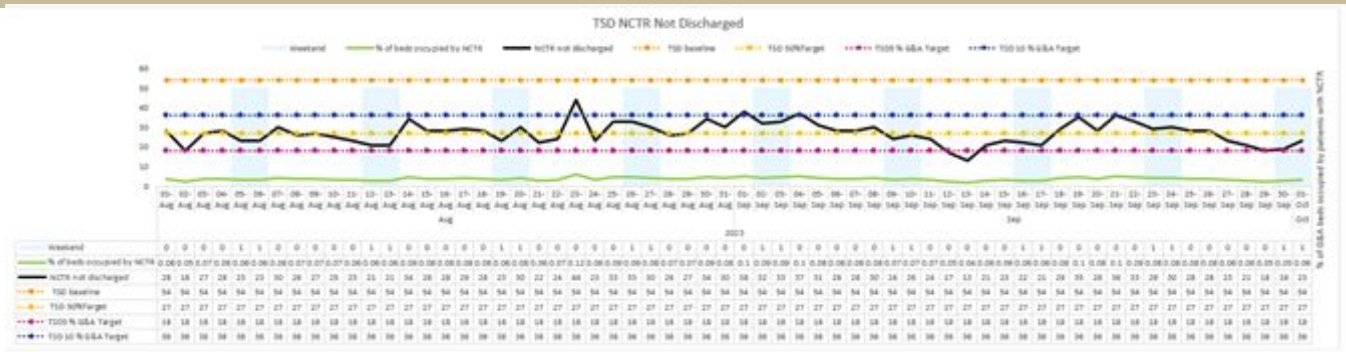
1. Increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

Risks/issues

- Further infection control issues
- Further Consultant industrial action
- Combination of the above

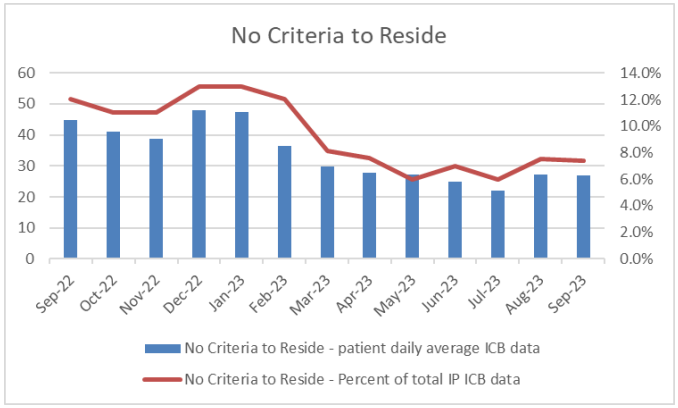
Exception report: No criteria to reside: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust



Performance

The average number of patients with No Criteria To Reside (NCTR) was 7.4% for September; **achieving 5% for two days in the month.** We continue to have the lowest NCTR across the ICB.



Operational update

Key actions that have supported the improvement in NCTR

- Trusted placement assessor.
- McCallum UEC - pilot ready to go ward model implemented.
- 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 Discharge Co-ordinator now attending NCTR meeting and taking actions to improve flow and validate patients converted to CTR on day of discharge.
- Discharge Hub is competing D2A visits to support discharge when locality lack capacity to meet demand.

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.
- Ongoing PDSA cycles for McCallum Ready to Go Ward.

Risks/issues

- Further infection control issues
- Further industrial action
- Local Care Market to support patient discharges
- Devon County Council prolonged sourcing and approval of placements due to financial constraints.

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

Torbay and South Devon NHS Foundation Trust

Performance

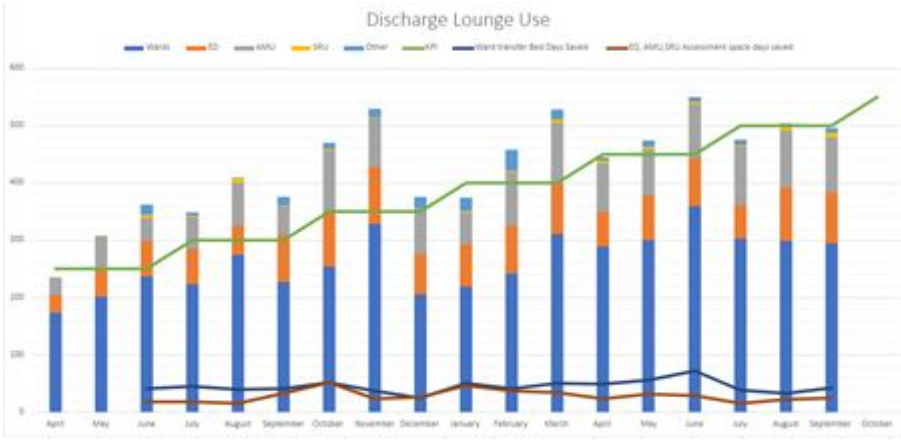
We saw a decrease in our overall general and acute discharges in September totalling 1533 compared with 1679 in August. Infection issues resulting in the loss of 504 bed days in month on wards contributed to this reduction. The percentage discharges pre-5pm and pre–noon stayed static compared with August.

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.

	Pre-noon	Pre 5PM
August	21.6%	70.6%
September	21.5%	70.9%

Operational update

The Discharge Lounge (DCL) remains a key part of the strategy for generating timely ward capacity. September saw 495 patients attend the discharge lounge.



Actions to complete next month

- Ward Nurse Flow Training Programme.
- Develop learning from industrial action successes – specifically overnight confirmation of tomorrows discharges, transport, and Care Planning Summaries.
- Discharge Audit – review implementation of best practice.
- Completion of Portal weekend live discharge list
- 'Home for lunch'.
- Patient transport and medication To-Take-Away monitoring via the Control Room.

Risks/issues

- Further infection issues.
- Further Industrial Action
- Consistent additional staffing support to the discharge team at weekends and senior cover.

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

Torbay and South Devon NHS Foundation Trust

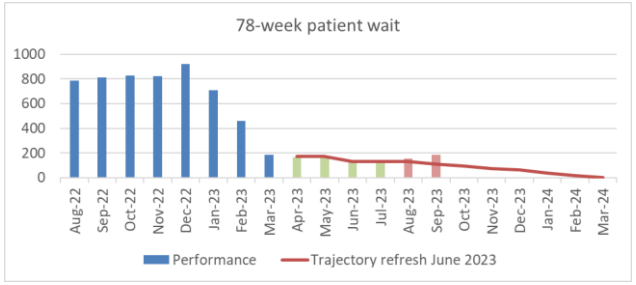
	Target March 2024	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Operational Plan trajectory Sept 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0	50	47	34	29	22	14	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	813	829	822	923	708	462	183	166	167	123	129	156	187	111
RTT 65 week wait incomplete pathway	0	2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1189
RTT 52 week wait incomplete pathway	Reduction	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	Not set
Patient waits over 2.5 years	0	24	24	17	12	9	6	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	77.3%	75%
Number of patients waiting longer than 62 days for treatment	138	333	331	229	253	225	130	114	107	111	100	89	120	105	170

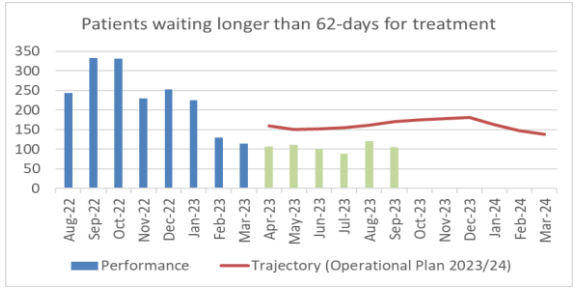
2023/24 RAG indicator

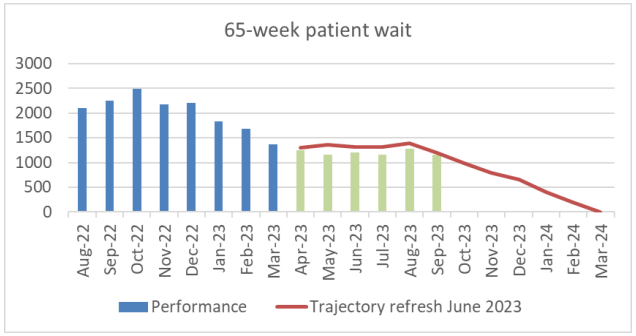
Meeting monthly trajectory

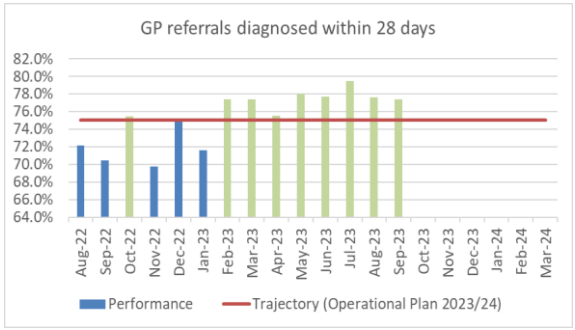
Not meeting monthly trajectory

Trajectories have been agreed across NOF exit indicators as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories. The Trajectory for reduction in patients over 78-week RTT has not been met in September. The impact of industrial action being the driving factor, the exception report (next page) describes in more detail the position and actions being taken.









Actions on-going this month

- Engagement with 'Further Faster' work programme.
- Targeted Investment Fund (TIF) day case theatres remains on track.
- Medefer virtual outpatient appointments - contract in place and now commenced in gynaecology.
- Continued utilisation of the Nightingale elective centre for orthopaedics, cataract surgery, and diagnostics.

Risks and Barriers

- Industrial action – impact of August and September strike actions more pronounced than in previous months. Greater impact on long-wait trajectories is observed in our 78-week position.
- Workforce – clinical, nursing, admin insourcing supporting gaps in clinical workforce capacity. HR programme to support recruitment and retention with ICS system support.

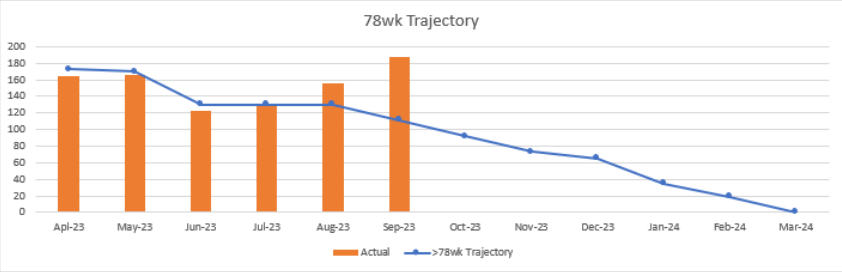
Exception report: 78 Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

Performance

The trajectory for reduction in patients over 78-week RTT has not been met in September.
In September, 187 patients remain waiting over 78-weeks against the target of 111.

	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>78wk Trajectory	173	170	130	130	130	111	92	73	65	35	19	0
Actual	165	166	123	129	156	187						
Revised FoT due to Indutrial Action - via Tier1					160	200	181					



Operational update

Failure to deliver the 130 target is due to the impact of Industrial Action in August and September. During these months 1,651 clinical events were lost due to industrial action. This has directly impacted on the numbers of treatments required to maintain the 78-week trajectory. Industrial action in October was more co-ordinated and lost capacity increased by 50% compared to August. This will have a direct impact on our October and particularly November forecasts.

Good work from the teams minimised the overall impact on the longest waits with the target for 78-week breaches only missed by 76 patients in September.

Based on current clock stop rates during strike and non-strike days it is estimated that >2,000 clock stops will be lost up to 31st March 24 as a result of industrial actions (assuming they continue into Q3/4

Actions to complete next month

- Assessment of insourcing and outsourcing plans to identify opportunities to compensate for lost capacity from Industrial Action in Q1 and Q2.
- Reassessment of ESRF plans will be required to address any growing shortfall in capacity.
- Engage with Devon ICB to further explore Devon-wide solutions for capacity gaps arising from Industrial Action.
- Increase in technical validation and direct patient contact to deliver the 12-week cycle of validation and potentially reduce waiting list pressures.

Risks/issues

- Continued Industrial Actions becoming more co-ordinated across staff groups and professions further limiting our ability to maintain clearance rates in our longest waiting groups.
- Recruitment of critical posts in theatres, clinical and support staff groups.

Quality and Safety Indicators – dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

Key							
⬆ = Performance improved from previous month		⬇ = Performance deteriorated from previous month		⬌ = No change			
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Reported Incidents – Severe (<6)		⬌
Reported Incidents – Death (<1)		⬆
Medication errors resulting in moderate harm (<1)		⬆
Medication errors - Total reported incidents (No target set)		
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears) (9 per year)		⬌
Never Events (<1)		⬌
Strategic Executive Information System (STEIS) (<1)		⬌
QUEST (Quality Effectiveness Safety Trigger Tool – red rated areas (<1)		⬌
Formal complaints - Number received (<20)		⬆
VTE - Risk Assessment on Admission (>95%) (Acute)		⬆
Hospital standardised mortality rate (HSMR) (<100)		⬆
Safer Staffing - ICO – Daytime (90% - 110%)		⬆
Safer Staffing - ICO – Night-time (90% - 110%)		⬆
Infection Control - Bed Closures - (Acute)(<100)		⬆
Hand Hygiene (>95%)		⬇
Number of Clostridium Difficile cases (COHA+HOHA)		⬇
Fracture Neck Of Femur - Time to Theatre <36 hours (>90%)		⬇
Stroke patients spending 90% of time on a stroke ward (>80%)		⬇
Mixed sex accommodation breaches (0)		⬌

Quality and Patient Safety Summary

Incidents
In September 2023, 1 incident of severe harm was reported onto the national StEIS (Strategic Executive Information system) . The incident was a patient fall resulting in a displaced right femur fracture.

VTE (Venous Thromboembolism) Assessment
The overall VTE conformity for all relevant in-patients in September 2023 is 95.2% which continues to be above the national target. However, the percentage of patients who have their assessments completed within 24 hours has fallen to 89.1% this month. It is noted that the extended/combined industrial action have had an impact on the timely completion of this assessment.
The Haematology Nurses continue to coordinate the positive VTE results and facilitate weekly reports to identify those patients who were treated, on an in-patient basis, within the previous 90 days of the result. This allows the relevant ISU to take ownership and investigate the level of harm sustained by the patient and any potential lapses in care. This gives assurance that positive VTEs are being identified in a timely manner and that appropriate investigations are being commenced and reviewed as per guidance.

Infection, Prevention, and Control
Although the number of closed bed days due to infection has slightly reduced there is still more work to be done with regards the Infection Prevention and Control care bundles such as Hand Hygiene. Targeted work is being undertaken through weekly teaching and audits in those areas that have not reached the expected standard. This is being overseen by the Lead Nurse for IPC and ADNPP's.

Maternity
There were no fetal loss in September 2023.
The Perinatal quadrumvirate have next round of culture and leadership training in early September. The SCORE survey will be sent out in mid-October and the dissemination and debriefing of results will be supported by an external organisation commissioned by NHSE.

Fractured neck of femur
58.3% of patients had access to theatre within the recommended time frame in September 2023 against a target of 90%. This is a sustained position, and more work needs to be undertaken. The Care Group are working through an improvement plan to ensure that beds can be ringfenced to ensure easier access to theatre. A change in theatre timetable in January 2024 may release more capacity.

Safer Staffing
The Registered Nurse fill rate for days during September 2023 was 98.1% which a slight increase on August fill rate of 97.9% and for night duty reported as 90.1% which again is an increase on August fill rate of 88.7%
The fill rate for Health care support workers for days is 103.8% which is a slight improvement on August fil rate of 101.5% and 117.3% which is reduced from 119.9% for night duty. A fil rate over 100% demonstrates an increase in staffing levels above establishment. Reasons for this includes, enhanced patient observation required or an increase in escalation areas being used.

CQC update 2021 and 2020 Action plans

CQC 2023 Well Led Inspection

The Trust has received its draft embargoed CQC report, with the factual accuracy checks being undertaken. The Trust will return the CQC factual accuracy documents within the agreed time and await the planned release date from the CQC. The areas inspected are also reviewing the document and creating action plans immediately that will be presented to the Care Groups for initial sign off and monitoring via the CQC Assurance Group.

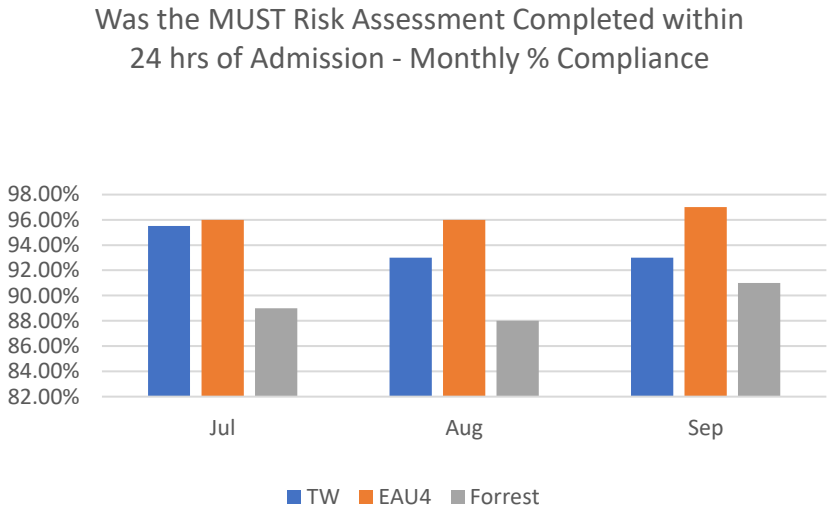
2021 CQC Focused Inspection – Quality Improvements

The daily 5 patient Risk Assessment audits continue to be being 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 completion within the 24-hour time standard, has a TW compliance rate of 93%. The recent CQC inspection recognised the improvement in undertaking clinical risk assessments within the Medical wards.

September 2023 Data

Audit results report Trust wide nutritional risk assessments completed within 24 hours remains at 93%

- ✓ Forrest Ward has continued to improve to over 90% - currently they are recording a 91% compliance rate
  - the ADNPP continues to work with the ward to increase compliance to 95%
- ✓ EAU4 compliance remains high at 97%



2020 CQC inspection

From the 2020 CQC inspection, the Trust has one remaining Must Do action. This is regarding staff appraisal achievement rates. Appraisals rates are monitored closely through each ISU/Care Group The Trust position in Aug 2023 is 80% compliance. 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, an effective rollout of appraisal training and a transition to electronic records.

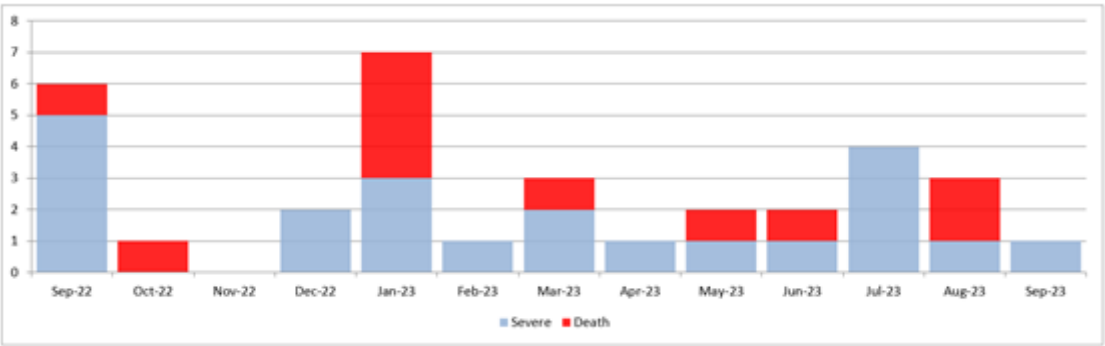
The most recent CQC inspection continues to identify appraisal rates as an area for improvement and this action will remain open in the 2023 Action plan.

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

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

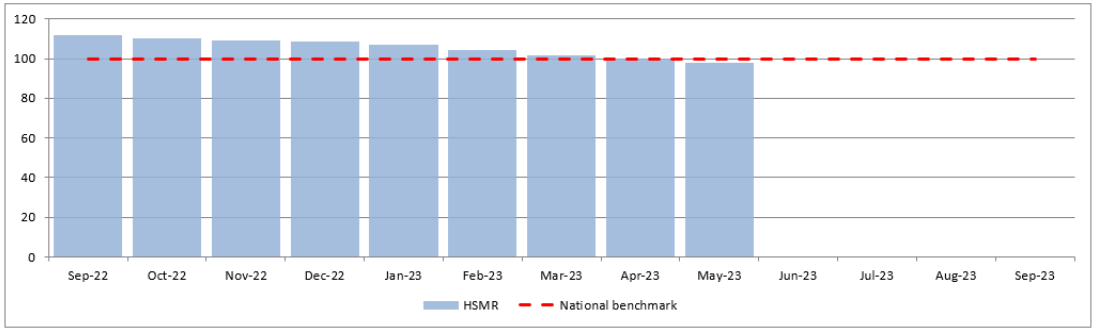


In September 2023, 1 severe incident was reported. The incident is being fully investigated as per the national policy.

The incident was a fall with a reported displaced right femur fracture.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
HSMR	112	110	108.9	108.7	106.8	104.2	101.9	99.9	98.1	0	0	0	0
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



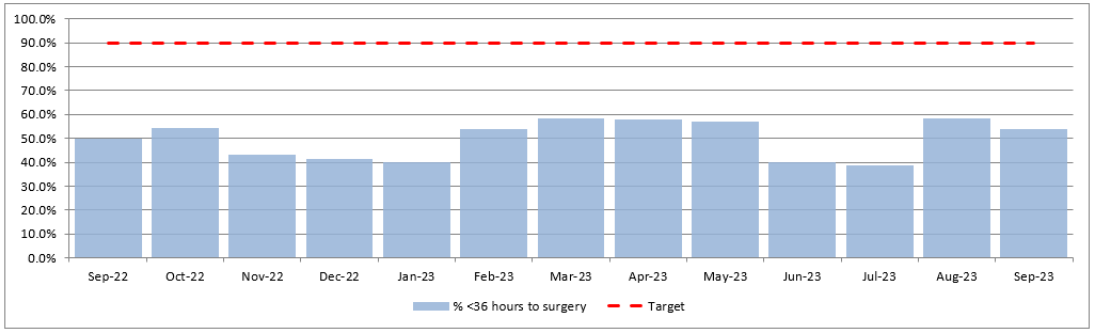
From October 2023 a one-month lag has been applied to the HSMR data to exclude the high numbers of null diagnosis codes experienced while coding processes occur. These null diagnosis effect the relative risk and the HSMR assessment resulting in an adversely inaccurate picture.
The latest HMSR for June 22 - May 23 is 98.1 (92.4 – 104.0), this is within the expected range compared to hospital trusts nationally. (↓). The Trust is one of five trusts in the region that is within the expected range with the second lowest HSMR.
The rolling twelve-month picture for weekday emergency HSMR continues to show a downward trend and has been within the expected range for eight data periods. The weekend emergency HSMR is now also within the expected range and demonstrates a downwards trend in the last two data periods.

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

Torbay and South Devon NHS Foundation Trust

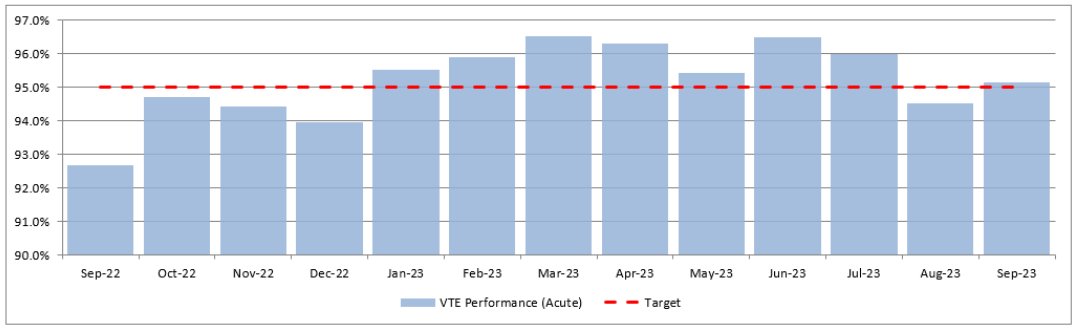
Fractured neck of femur - <36 hours to surgery

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
% <36 hours to surgery	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%
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%



Acute VTE risk assessment on admission

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
VTE Numerator	5102	5433	5521	4896	5631	5437	6050	5152	5104	2563	5911	5717	5624
VTE Denominator	5505	5737	5847	5210	5894	5669	6267	5349	5349	2656	6157	6048	5910
VTE Performance (Acute)	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%
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%



Fractured Neck of Femur

58.3 % of patients had access to theatre within the recommended time frame in September 2023 against a target of 90%. Reasons for failing to achieve the required standard includes;

- Increased demand for theatre capacity for patients with fractured hips
- Non-ring fencing of trauma beds

There has been a commitment from the Winter Planning Board to ring fence beds on Ainslie to support this vulnerable group of patients however this has been difficult to enact due to operational pressures within the Trust.

However, this a planned changed to the theatre timetable in January 24 which should support additional capacity.

VTE assessment

The overall VTE assessment conformity for all relevant in-patients in September 2023 is 95.2%, which continues to be above the 95% national target.

The areas non-complaint with undertaking risk assessments within 24-hours are:

- EAU4 93.3%
- Ella 36.4%
- George Earle 76.9%
- Simpson 55.6%

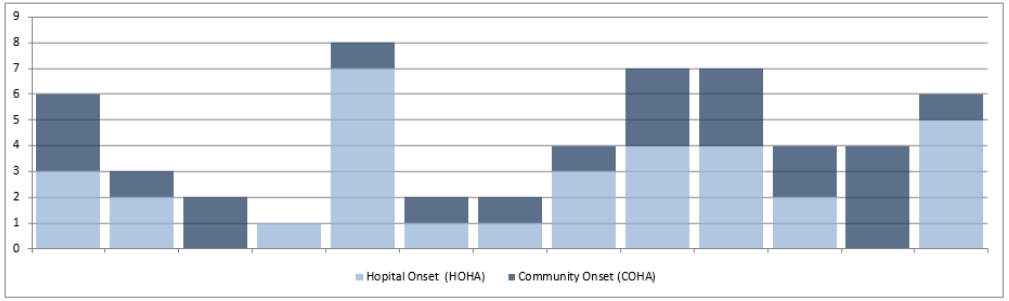
ADNPPs review the accuracy of data submissions from the Safety Assessment Audit and identify areas for improvement where required. This will also be discussed at ward safer meetings.

Quality and Safety exception report - Infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

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

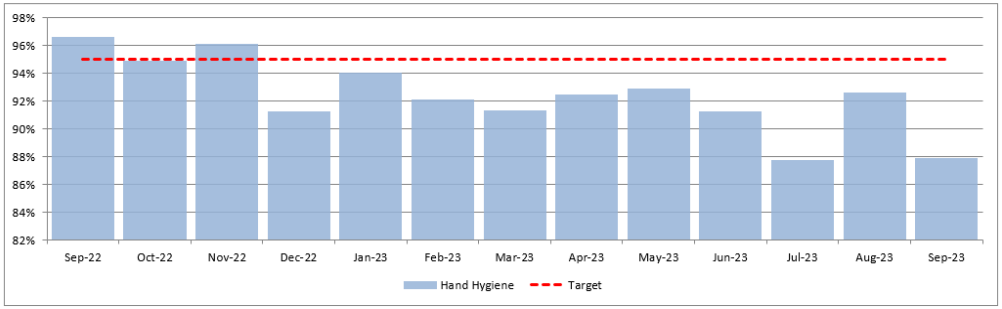


During September 6 cases of Clostridium Difficile were reported.

September saw an increase in the number of cases of C Diff reported. There was an outbreak on one high risk ward and all precautions were taken to manage within IPC national guidance

Hand Hygiene

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Hand Hygiene	97%	95%	96%	91%	94%	92%	91%	92%	93%	91%	88%	93%	88%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



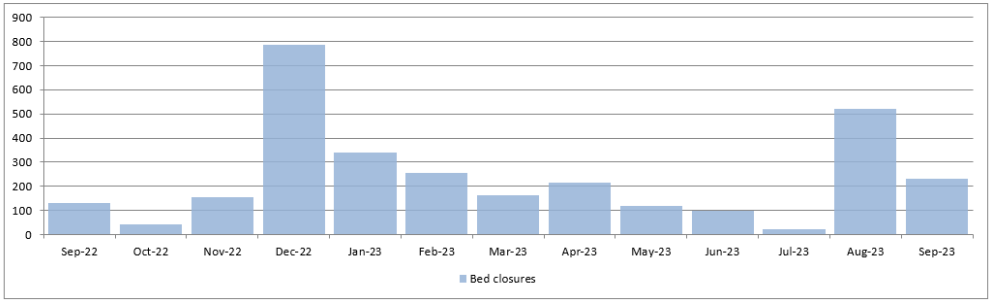
There has been a decrease in compliance in the Trust wide hand hygiene audits for September 2023.

The Infection, Prevention, and Control team continue to provide targeted training on hand hygiene and have been using methods such as the 'glowbox' to ensure compliance.

However local action plans have now been developed to ensure Matron oversight.
ADNPP oversight has commenced weekly.

Infection control - Bed days lost (Acute)

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Bed closures	132	42	156	786	339	254	164	217	120	99	24	522	231



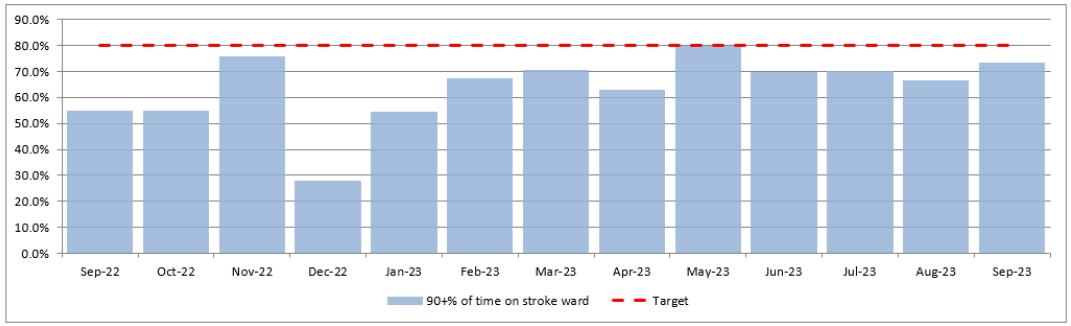
Bed closures decreased from 522 in August to 231 in September.
There was a sporadic outbreaks in the number of patients being admitted with Covid-19 as well as outbreaks of Norovirus.
Further advice and guidance has been sent to all staff with regards COVID-19 advice retesting and precautions.

Quality and Safety exception report – stroke care

Torbay and South Devon NHS Foundation Trust

Stroke

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
90+% of time on stroke ward	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%	73.3%
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

- 73.3% of patients spent more than 90% of their stay on the stroke unit which is an improved position from August 2023;
- 20.5 % of patients were admitted to the Stroke Unit with 4 hours of admission; this metric is a comparable with last month;
- 100% of patients received a nutrition screen and 93.3% of patients a continence plan within 12 hours;
- 60% of patients received a scan within one hour;
- 91.1% of patients received a scan within 12 hours which is a comparable position on last month
- 86.7 % of patients saw a stroke nurse within 24 hours which is a slightly improved position from August 2023.

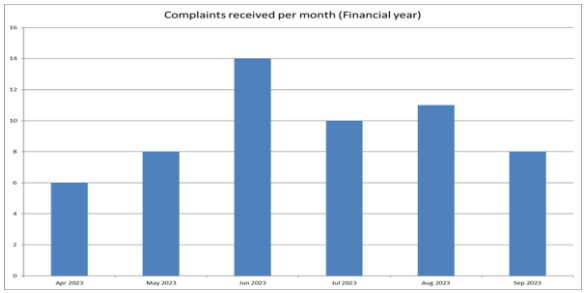
Stroke performance governance and oversight

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.

A detailed report on stroke performance was presented at the Quality Assurance Committee earlier this month and actions agreed.

The recent CQC inspection has highlighted the challenges accessing stroke services and this will remain a focus for the organisation over the next few months.

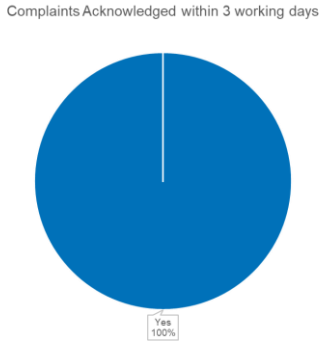
Total Number of Complaints and PAL's contacts during September 2023



The number of complaints received in this financial year to date stands at 57; an average of 10 a month this is lower than the same period last year by 27 complaints which equates to a 32% decrease. Apart from June, with 14 complaints reported, all other figures are consistently below the lower control limit of expected volume of complaints per month [Mean = 20 / LCL = 13 / UCL = 27, averages calculated by records received since the Trust integrated circa 2016].

On a month-by-month basis, an average of 10 complaints was received per month, and 13 complaints were on average closed per month.

ADNPP's have been working hard with their teams regarding closing of complaints and this is reflected in the last 6 months where 4 months have seen greater numbers closed than received.

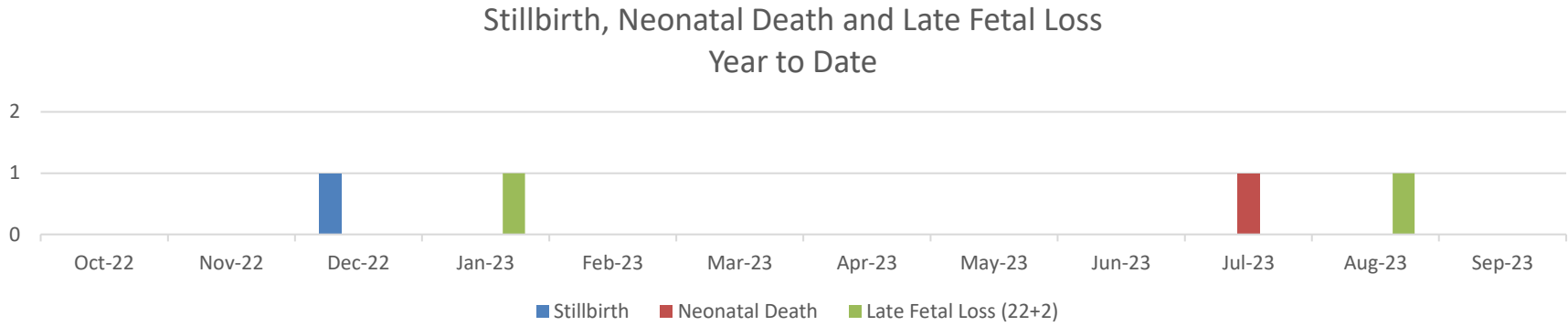


Within the 57 complaints received in the 2023/24 financial year, all are reported as being acknowledged within 3 working days.

Quality and Safety- Perinatal Clinical Quality Surveillance September 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

- There were no fetal losses in September.



	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Running Total
% of women booked for continuity of carer	54.9%	52.2%	49.7%	61.0%	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	90.4%	76.9%	71.0%
Number of Stillbirths	0	0	1	0	0	0	0	0	0	0	0	0	1
% Robson Group 1	12.0%	22.9%	12.0%	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	11.5%	15.3%
% Robson Group 2	38.2%	36.4%	36.4%	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	23.1%	19.0%	40.9%	32.1%
% Robson Group 5	57.1%	90.5%	90.9%	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	94.4%	84.4%
% Breastfeeding at Delivery	63.9%	64.7%	63.0%	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	78.4%	67.6%	75.5%	69.0%

- The new implementation tool to enable providers to assess compliance against Saving Babies Lives V3 has been circulated. This will form part of the assurance mechanism for CNST compliance for this safety action and will need to be signed off through LMNS/ICS.
- The Perinatal quadrumvirate have next round of culture and leadership training in early September. The SCORE survey will be sent out in mid-October and the dissemination and debriefing of results will be supported by an external organisation commissioned by NHSE

Workforce Status

As part of the review and development of the IPR, the workforce elements of this report has been completely reviewed and is on an iterative process of on-going improvement. The report provides an update on progress in delivering the Trust-wide workforce implications and mitigating actions of the:

- operational plan
- local workforce factors impacting NOF4 exit criteria and
- A revised format for the overview of workforce metrics via a new dashboard, endorsed by the People Committee, which will support the new organisational governance structure to highlight specific risks and actions.

Performance exceptions and actions

The table below provides a high-level overview of the exceptions and actions to mitigate, further detail can be found in the subsequent slides.

Exceptions		Actions to mitigate
Workforce implications of the operational plan		
Substantive WTE	Sep 2023 **63** WTE over plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	Sep 2023 **69** WTE over plan	
Agency WTE	Sep 2023 **80** WTE over plan	
Local workforce factors affecting NOF4 exit criteria		
Workforce is one of the key factors affecting specialties that are challenged in delivering RTT performance targets. Substantive clinical and consultant vacancies are held across several of the most challenged areas.		• workforce modelling • the development of marketing materials • enhanced collaboration with local Trusts within the Devon system
Trust Level workforce KPI's		
Sickness, month % (target 4%)	Sep 2023 **4.97%**	• visibility of cost-centre level data is being shared and discussed with Care Groups, as well as Care Group governance and assurance meetings to develop and support improvement plans • Management induction and development to include training in sickness absence management
Sickness, 12m rolling % (target 4%)	Sep 2023 **5.20%**	
Achievement review rate (target 90%)	Sep 2023 **78.93%**	

Trust Level Operational Plan – Workforce Implications

Torbay and South Devon NHS Foundation Trust

Local and system level operational plans are required to meet the requirement for 0% total workforce growth (substantive, bank and agency). The table below demonstrates how we are currently progressing against our overall plan, the associated headlines are as follows:

- The Trusts **substantive** workforce is **63 WTE** over plan in September 2023, worsening from the previously reported 29 WTE above plan in August.

- Areas of growth since August have been seen in the Nursing and Midwifery staff group showing an increase of **20 WTE,** also the Support to Clinical Staff group which includes Support Workers have increased by **12 WTE.**

- Use of our temporary workforce has increased between August and September and remains above plan. This is largely as a result of Industrial Action (Junior Doctors and Consultants 19-23rd September) and some increase in sickness absence. The industrial action was not factored into any of the operational plans.

  - **Bank usage** has decreased by 5% since August, equating to 19.12 WTE and is **69 WTE** above plan.
  - **Agency usage** has increased by 16% since August equating to 29.41 WTE and is **80 WTE** over plan in August.

To mitigate these increases, and support the Trust to achieve its substantive, bank and agency plans, we continue to operate enhanced vacancy and agency scrutiny controls. The new Interim Vacancy Scrutiny Group now meets weekly to scrutinise;

- All clinical areas operating at band 6 and higher
- All corporate service and non-clinical roles (non-patient facing)
- Interim and Agency Requests

	Plan - As at the end of																	
	Plan Apr 23	Apr 23 Actual	Plan May 23	May 23 Actual	Plan Jun 23	Jun 23 Actual	Plan Jul 23	Jul 23 Actual	Plan Aug 23	Aug 23 Actual	Plan Sep 23	Sep 23 Actual	Plan Oct 23	Plan Nov 23	Plan Dec 23	Plan Jan 24	Plan Feb 24	Plan Mar 24
	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce	6,498	6636.15	6,508	6662.09	6,520	6788.34	6,522	6707.55	6,531	6727.04	6530	6776.66	6,552	6,579	6,609	6,619	6,622	6,644
Total Substantive	6,170	6188.10	6,170	6168.33	6,178	6196.22	6,180	6266.13	6,184	6213.48	6,190	6252.81	6,197	6,199	6,212	6,222	6,225	6,241
Registered Nursing, Midwifery and Health Visiting Staff	1387.8	1382.73	1387.78	1381.35	1387.78	1384.89	1387.78	1379.20	1389.03	1390.10	1395.03	1409.20	1399.03	1401.03	1411.74	1414.74	1417.62	1417.67
Registered/ Qualified Scientific, Therapeutic and Technical staff	962.48	966.84	962.48	964.18	962.48	967.02	962.48	974.39	962.48	975.10	962.48	984.47	962.48	962.48	962.48	962.48	962.48	972.87
Support to Clinical Staff	1443.3	1440.32	1443.25	1426.86	1443.25	1425.82	1443.25	1435.83	1443.25	1411.46	1443.25	1423.57	1443.25	1443.25	1443.25	1443.25	1443.25	1440.05
NHS Infrastructure support	1789.3	1817.12	1789.33	1817.42	1789.33	1829.83	1789.33	1836.24	1789.33	1835.37	1789.33	1833.32	1789.33	1789.33	1789.33	1793.18	1793.18	1801.95
Medical and Dental	579.7	573.68	579.70	571.10	587.60	574.65	589.60	633.05	592.60	594.17	592.60	594.97	595.60	595.60	597.60	600.60	600.76	600.76
Total Bank	237	282.02	243	289.44	247	362.58	246	273.16	251	337.19	249	318.07	251	270	281	280	282	281
Total Agency	91	166.03	95	204.32	95	229.54	96	168.26	96	176.37	91	205.78	104	110	116	117	115	122

Service Level – Workforce Implications affecting NOF4 exit

NHS Torbay and South Devon NHS Foundation Trust

Referral to Treatment Time (RTT) and Fragile Services

The following specialties face significant challenges in delivering the activity needed to reduce long waiting times.
The table below summarises the workforce risks and actions that are being taken.

Speciality	Workforce issues and actions
ENT	**Issue:** Currently have 2 consultant vacancies meaning they are operating 1:4 consultant rota which is unsustainable and poses risk to burnout. However 1 post has now filled. **Mitigating action:** A bespoke recruitment video has been developed to enhance marketing and attraction.
Urology	**Issue:** Continue to have 2 consultant vacancies being filled by locums. **Mitigating actions:** Developing a clinical model with Royal Devon for out of hours cover and a long term plan with hot and cold sites
Gynae	**Issue:** Gynae clinic demand profiles and Okenden requirements require additional clinical capacity. **Mitigating actions:** Undertaking team job planning and a full service review to ensure that there is a single plan that encapsulates all of the actions and interventions that are needed to reduce the risk
Colorectal / Upper GI	**Issues:** Consultants moved to a 2nd on-call rota during COVID which has impacted job plans and the delivery of elective capacity. There have been 3 SpR gaps on the general surgery rota over the last 2 years. **Mitigating actions:** Job plans are currently being signed off to increase elective activity. Locally Employed Doctors have been recruited to fill the SpR gaps and start in December. From December General Surgery will have zero agency usage for their Junior Doctor rotas.
Interventional Radiology	**Issue**: Since April 23, the 24/7 Interventional Radiology (IR) service has not been able to provide out of hours (OOH) cover due for Exeter and Torbay as there has been insufficient substantive IR Consultants in post. **Mitigation**: In July 2023 a 10-week trial, established by the Peninsular Acute Sustainability Programme, for a 24/7 IR on call service covering North Devon, Taunton, Yeovil, Torbay and Exeter. During the trial, the on-call service will be provided at a single centre, with patients transferred to Musgrove Park Hospital (MPH), Taunton for emergency IR treatment.
Operating Department Practitioners	**Issue:** Local and national shortage of Operating Department Practitioners (OPD), which is impacting on elective recovery and coverage of emergency obstetric theatre service out of hours. **Mitigation:** Active and on-going recruitment campaigns to support the filling of ODP vacancies, and the use of ODP agency is being explored. A programme of international recruitment is piloted, with interviews being held in October 2023. A business case has been submitted to support a rolling programme of apprenticeships for ODPs.

Trust Level Workforce – KPI's

Torbay and South Devon NHS Foundation Trust

Indicator	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Performance
Month Sickness %	<4%	5.86%	5.39%	6.54%	5.26%	4.59%	4.63%	5.07%	4.46%	4.88%	4.98%	4.96%	4.97%	
12 Mth Rolling Sickness %	<4%	5.71%	5.69%	5.76%	5.69%	5.58%	5.62%	4.96%	5.29%	5.32%	5.18%	5.19%	5.20%	
Achievement Rate %	>90%	76.61%	77.96%	76.70%	77.68%	76.71%	76.87%	77.87%	78.12%	78.08%	78.08%	79.92%	78.93%	
Labour Turnover Rate	10-14%	13.66%	13.74%	13.48%	13.33%	13.09%	12.85%	12.92%	12.74%	12.46%	12.71%	12.46%	12.16%	
Overall Training %	>85%	88.65%	89.10%	89.70%	89.94%	90.09%	90.45%	90.72%	91.24%	91.74%	91.49%	91.97%	91.59%	
Nuring Staff Average % Day Fill Rate- Nurses		99%	99%	92%	92%	91%	93%	92%	96%	100%	96%	98%	98%	
Nuring Staff Average % Night Fill Rate- Nurses		89%	86%	87%	88%	87%	88%	91%	90%	89%	90%	89%	90%	
Safer Staffing- Overall CHPPD		7.72	7.75	7.54	7.72	7.83	7.75	7.9	8.05	7.99	8.4	8.17	8.08	

Sickness – The operational plan trajectories reflects revised KPI's for sickness absence based upon the previous 5 years trend data. We have seen an improvement in the 12 months ending September to **5.20%**, which is below our plan of 5.27% and lower than the same time last year (5.74%). Rolling sickness cost at the end of September was £11.6m which whilst lower that the £12m in September 2022, represents a significant opportunity for improvement.

Turnover – Following marginal increases in April and July, there has been a general downward trend in turnover since the start of the calendar year. This remains the case in September with an actual turnover of **12.16%**, against a plan of 12.99% and representing an improvement from the previous month. Turnover is significantly lower that the same time last year (13.88%). Actions as part of the ICS Retention project are showing a positive impact e.g. stay interviews, legacy mentors, 5 high impact measures

Mandatory Training –There has been a steady upward trend in overall compliance over the last 12 months. Compliance has decreased slightly by 0.38% in September to **91.59%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **78%** and Information Governance at **87%.**

Achievement Review – Compliance has dropped by just under 0.99 % in September to **78.93%** but remains below the target of 90%. To aid improvement the data is made available to cost centre managers and will continue to be part of the revised Care Group dashboard.

Safer Staffing – Care hours per patient day (CHPPD) and planned versus actual

Torbay and South Devon NHS Foundation Trust

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	8.10	3.90	0.00	4.10	9	19	0	3	30.0%	63.3%	0.0%	10.0%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.30	4.10	0.00	3.20	17	28	0	4	56.7%	93.3%	0.0%	13.3%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.90	3.50	0.00	5.40	0	7	0	0	0.0%	13.3%	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	2	0	0	0.0%	6.7%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	8.60	3.90	0.00	4.70	0	6	0	0	0.0%	20.0%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.40	3.30	0.00	3.10	16	19	0	8	53.3%	63.3%	0.0%	26.7%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.70	4.50	0.00	4.20	12	21	0	8	40.0%	70.0%	0.0%	26.7%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	10.20	5.00	0.00	5.20	3	7	0	5	10.0%	23.3%	0.0%	16.7%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	8.10	4.50	0.00	3.60	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	7.70	3.20	0.00	4.40	8	15	0	5	26.7%	50.0%	0.0%	16.7%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	30.80	30.50	0.00	0.30	1	1	0	27	3.3%	3.3%	0.0%	90.0%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	6.90	3.10	0.00	3.70	9	0	0	15	30.0%	0.0%	0.0%	50.0%	7.74	4.74	0	2.91
Louisa Cary	10.89	8.47	0.00	2.42	12.60	8.70	0.00	4.00	6	15	0	2	0.0%	50.0%	0.0%	6.7%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	7.00	4.10	0.00	2.90	1	7	0	3	3.3%	23.3%	0.0%	10.0%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.00	4.70	0.00	3.30	11	0	0	29	36.7%	0.0%	0.0%	96.7%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	10.40	8.00	0.00	2.40	11	8	0	11	36.7%	26.7%	0.0%	36.7%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.60	3.60	0.00	5.10	0	4	0	0	0.0%	13.3%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	8.90	3.80	0.00	5.20	20	15	0	19	66.7%	50.0%	0.0%	63.3%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.70	3.90	0.00	3.70	1	3	0	5	3.3%	10.0%	0.0%	16.7%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	7.10	2.90	0.00	4.20	13	17	30	1	43.3%	56.7%	100.0%	3.3%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.30	3.40	0.00	3.90	7	11	0	9	23.3%	36.7%	0.0%	30.0%	7.74	4.74	0	2.91
Newton Abbot - Teign Ward	6.40	3.20	0.00	3.20	6.20	3.00	0.00	3.10	18	19	0	15	60.0%	63.3%	0.0%	50.0%	7.74	4.74	0	2.91
Newton Abbot - Templar Ward	6.50	2.97	0.00	3.53	6.30	3.00	0.00	3.40	12	12	0	16	40.0%	40.0%	0.0%	53.3%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.50	2.70	0.00	3.80	13	19	0	8	43.3%	63.3%	0.0%	26.7%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.50	4.18	0.03	3.29	8.08	4.24	0.00	3.85
Total Planned Beds / Day	520							
Days in month	30							

- The RN actual CHPPD has been reported as 4.24 in September but still remains below the carter recommendation of 4.7.
- The actual HCA CHPPD was 3.85 in August 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 September the Trust was operationally challenged with 10 days in OPEL 4 and 19 days at OPEL 3
- The planned CHPPD total was reported as 7.50 with an actual of 8.08 which reflects an increase in escalation areas due to operational challenges.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

Sep-23

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff			Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Alnalle	1725	1619	0	0	1725	1829	1380	1288	0	0	1035	1210	737	93.9%	0.0%	106.0%	93.3%	0.0%	116.9%
Allerton	2814	2417	0	0	1035	1450	1380	1109	0	0	1035	1299	856	85.9%	0.0%	140.1%	80.3%	0.0%	125.5%
Cheetham Hill	1725	1735	0	0	2070	2196	1035	1093	0	0	1380	2092	797	100.6%	0.0%	106.1%	105.6%	0.0%	151.6%
Coronary Care	1380	1432	0	0	0	81	1035	1035	0	0	0	0	370	103.8%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromle	1622	1779	0	0	863	1947	1035	1040	0	0	690	1482	730	109.7%	0.0%	225.8%	100.4%	0.0%	214.7%
Dunlop	1380	1344	0	0	1208	1278	1035	1035	0	0	1035	989	723	97.4%	0.0%	105.8%	100.0%	0.0%	95.5%
EAU4	1725	1847	0	0	1380	1668	1725	1421	0	0	1380	1346	719	107.1%	0.0%	120.9%	82.4%	0.0%	97.5%
Ella Rowcroft	1035	1082	0	0	1380	1405	989	851	0	0	690	622	388	104.5%	0.0%	101.8%	86.0%	0.0%	90.1%
Warrington	1035	1281	0	0	690	884	690	851	0	0	690	849	475	123.7%	0.0%	128.2%	123.3%	0.0%	123.0%
George Earle	1725	1690	0	0	2070	1982	1035	944	0	0	1380	1629	812	97.9%	0.0%	95.8%	91.2%	0.0%	118.0%
ICU	3105	2393	0	0	345	52	3105	2243	0	0	0	0	152	77.1%	0.0%	15.1%	72.2%	0.0%	0.0%
McCullum (Escalation)	690	879	0	0	1035	965	690	711	0	0	1035	934	507	127.4%	0.0%	93.3%	103.0%	0.0%	90.2%
Louisa Cary	2415	2135	0	0	690	786	2415	1490	0	0	690	877	419	88.4%	0.0%	113.9%	61.7%	0.0%	127.1%
John Macpherson	1035	860	0	0	690	633	690	633	0	0	345	399	361	83.1%	0.0%	91.8%	91.7%	0.0%	115.7%
Midgley	1725	2119	0	0	1725	1214	1380	1486	0	0	1380	1362	774	122.8%	0.0%	70.4%	107.7%	0.0%	98.7%
SCBU	1035	774	0	0	345	292	1035	835	0	0	345	199	202	74.7%	0.0%	84.5%	80.7%	0.0%	57.5%
Simpson	1725	1879	0	0	2070	2300	1035	1058	0	0	1380	1882	823	108.9%	0.0%	111.1%	102.2%	0.0%	136.4%
Turner	1380	1289	0	0	1725	1368	690	692	0	0	1380	1334	524	93.4%	0.0%	79.3%	100.2%	0.0%	96.6%
New Forrest Ward	1725	1917	0	0	1380	1685	1380	1472	0	0	1380	1551	865	111.1%	0.0%	122.1%	106.6%	0.0%	112.4%
Total (Acute)	*31001*	*30470.4*	*0*	*0*	*22425*	*24013.75*	*23759*	*21281.5*	*0*	*0*	*17250*	*20051.1*	*11234*	98.3%	0.0%	107.1%	89.6%	0.0%	116.2%
Brixham	840	874	420	0	1260	1419.5	990	759	0	0	660	980	567	104.0%	0.0%	112.7%	76.7%	0.0%	148.5%
Dawlish	840	896.25	0	0	1050	1048.75	720	704.5	0	0	660	824.5	476	106.7%	0.0%	99.9%	97.8%	0.0%	124.9%
NA - Teign Ward	1890	1732.3	0	0	1890	1568.5	990	980.75	0	0	990	1243.5	895	91.7%	0.0%	83.0%	99.1%	0.0%	125.6%
NA - Templar Ward	1680	1611	0	0	2100	1862	990	1012	0	0	1080	1122.25	884	95.9%	0.0%	88.7%	102.2%	0.0%	103.9%
Totnes	840	801.5	0	0	1260	1215.5	720	646.5	0	0	660	762.5	527	95.4%	0.0%	96.5%	89.8%	0.0%	115.5%
Organisational Summary	37091	36385	420	0	29985	31128	28169	25384	0	0	21300	24984	14583	98.1%	0.0%	103.8%	90.1%	0.0%	117.3%

- The Registered Nurse fill rate for days during September was 98.1% which is a slight increase in August fill rate of 97.9 % and for night duty reported as 90.1% which is an increase on the previous months fill rate of 88.7%.
- The fill rate for Health care support workers for days during September was 103.8% which is an increase on August fill rate of 101.5% . For night duty reported as 117.3% which is a decrease on the previous months fill rate of 119.9%
- The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

Community and Social Care Indicators - dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

Key							
⬆ = Performance improved from previous month ⬇ = Performance deteriorated from previous month ⬌ = No change							
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Opiate users - % successful completions of treatment (quarterly 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		
Urgent Community Response 2 hours		
Urgent Community Response 2 to 48 hours		
Permanent admissions (18-64) to care homes per 100k population (ASCOF) (14)		⬇
Permanent admissions (65+) to care homes per 100k population (ASCOF) (450)		⬌
Proportion of clients receiving direct payments (ASCOF) (25%)		⬌
% reablement episodes not followed by long term SC support (83%)		⬇

Operational Performance Indicators - dashboard of key metrics

NHS Torbay and South Devon NHS Foundation Trust

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

A&E - patients seen within 4 hours		↑
Referral to treatment - % Incomplete pathways <18 weeks		↑
Cancer - 62-day wait for first treatment - 2ww referral		↓
Diagnostic tests longer than the 6-week standard		↓
Dementia Find		↓
Cancer - Two week wait from referral to date 1st seen		↑
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		↑
Cancer – 28-day faster diagnosis standard		↓
Cancer - 31-day wait from decision to treat to first treatment		↓
Cancer - 31-day wait for second or subsequent treatment - Drug		↔
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		↓
Cancer - 31-day wait for second or subsequent treatment – Surgery		↑
Cancer – 62-day wait for first treatment – screening		↓
Cancer - Patient waiting longer than 104 days from 2 week wait		↓
RTT 65-week wait incomplete pathway		↑
RTT 78-week wait incomplete pathway		↓
RTT 104-week wait incomplete pathway		↔
On the day cancellations for elective operations		↓

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

NHS
Torbay and South Devon
NHS Foundation Trust

Monthly Financial Performance Report

M06 (Period Ended Sep-23)

Contents Page

Torbay and South Devon NHS Foundation Trust

Executive Summary

Torbay and South Devon NHS Foundation Trust

Description	YTD Bud £000	YTD Act £000	Var £000	Var %	YTD R.A.G	F'cast Bud £000	F'cast Exp £000	Var £000	Var %	F'cast R.A.G
Operating Income	320,628	324,393	3,765	1.2%		638,432	638,432	0	0.0%	
Operating Expenditure and Financing Cost	(343,163)	(370,233)	(27,070)	(7.9%)		(671,008)	(671,008)	0	0.0%	
Surplus / (Deficit)	**(22,535)**	**(45,840)**	**(23,305)**	**103.4%**		**(32,575)**	**(32,575)**	**0**	**0.0%**	
Add back: Donated Assets, Cost on Impairment	(52)	20,855	20,907	(40,090.6%)		2	2	0	0.0%	
Adjusted Surplus / (Deficit)	**(22,588)**	**(24,985)**	**(2,398)**	**10.6%**		**(32,573)**	**(32,573)**	**0**	**0.0%**	
Capital (CDEL)	21,502	18,235	(3,267)	(15.2%)		56,755	47,851	8,804	15.7%	
Cash & Cash Equivalents	15,864	19,193	3,329	21.0%		14,975	14,975	0	0.0%	

As at M06, the Trust reported an adverse financial variance to plan of **£2.398m**. This is primarily driven by the net impact of the ongoing Industrial Actions. **£1.638m** relates to the net cost implication and **£0.760m** for potential Elective Recovery Fund (ERF) clawback due to activity delivery being lower than planned. At this stage of the year, we are still formally reporting a no variance to plan in the forecast position, however the overall likely forecast variance to plan is £32.3m (please see details on slide 4). We have started a conversation within the Integrated Care System (ICS) regarding the timing and appropriate governance routes to follow before jointly reporting a likely in-year forecast variance to plan around M9 (December).

Against our in-year CIP target of **£46.58m**, the number of schemes currently showing as green and having plans in place for delivery is totalling **£36.6m** for the whole year, leaving a remaining **£9.98m** still to be identified. Against the £36.6m approved schemes we are currently reporting a confirmed delivery of **£23.52m**, of which **£19.63m** (83%) being Recurrent schemes.

Please also note that the YTD impact of Industrial Actions has been reported to the Integrated Care Board (ICB) and NHS England and Improvement (NHSE/I) as required.

Risks & Mitigations to Forecast Outturn

Torbay and South Devon NHS Foundation Trust

Ref	Risk Description	Best Case £'000	Most Likely £'000	Worst Case £'000
R01	Unfunded COVID Capacity	(3,000)	(3,000)	(3,000)
R02	Additional cost risk (Non Pay inflation) e.g. Utilities	(2,400)	(2,400)	(3,600)
R03	Pay award cost pressure	(1,500)	(1,500)	(1,500)
R04	High cost drugs growth	(500)	(1,000)	(2,500)
R05	Pay Overs Spend / (Medical Agency Locum)	(3,500)	(3,500)	(3,500)
R06	Matching Out of hours rate with RDUH East Rate	(500)	(500)	(500)
R07	Efficiency risk	(881)	(4,204)	(7,700)
R08	System strategic efficiencies risk	(4,538)	(5,800)	(7,298)
R10	Section 75 shortfall for Adult Social Care	0	(5,000)	(5,000)
R11	Diagnostic Cost Pressure due to backlog	(1,000)	(1,200)	(1,500)
R12	ERF income risk	(1,100)	(1,400)	(1,700)
R13	Industrial action costs	(1,638)	(1,638)	(2,069)
R14	B2 to B3 re-banding (from 1st April 2023)	0	(2,060)	(2,060)
R15	Unfunded Capital Depreciation	(400)	(400)	(700)
R16	ASC Volume and Complexity Risk	(5,800)	(6,900)	(7,200)
Sub Total		**(29,581)**	**(38,058)**	**(51,137)**
	Assumed funding for pay award pressure	1,500	1,500	1,500
	Assumed funding on cost for IA (excl.ERF)	1,638	1,638	2,069
	Band 2 to Band 3	0	2,060	2,060
	Section 75 Adult Social Care ICB Funding	0	3,000	0
Total Net Risk		**(23,619)**	**(32,304)**	**(44,198)**

This table highlights the underlying forecast variance to plan split by best, most likely and worst-case scenario.

The net position of £32.3m variance to plan is not acceptable to NHSE.

Independent review had been commission by the ICB on these forecast risks and we are currently working with the ICB and completing the diligence on these forecast variance to plan before we can formally report to NHSE. Mitigating action are currently being worked up jointly to minimize the forecast variance risks.

Via the Trust's own senior leadership team, FPDC and Board, collective decisions and actions are required around the operational steps that will be taken to delivery these overspend reductions and the operational performance impact in doing so.

In Month (Sep-23) Position by Category

Torbay and South Devon NHS Foundation Trust

	M06 Bud £000	M06 Act £000	Var £000
Patient Income – Block incl. Torbay Council	44,756	45,264	508
Patient Income – Variable	4,081	4,402	321
ASC Client Contribution	1,221	1,685	465
Other Patient Income incl. Private Patient	272	171	(101)
Torbay Pharmaceutical Sales	1,710	1,946	235
Other Income	2,428	2,990	562
Total Income (A)	**54,468**	**56,459**	**1,990**
Pay – Substantive	(26,576)	(25,685)	891
Pay – Bank & Agency	(1,935)	(3,350)	(1,415)
Non-Pay – Other	(14,435)	(17,304)	(2,869)
Non- Pay – ASC / CHC	(11,080)	(11,907)	(827)
Financing & Other Costs	(2,979)	(1,844)	1,135
Total Expenses (B)	**(57,006)**	**(60,091)**	**(3,085)**
Sub-Total Surplus / (Deficit) (A+B)	**(2,537)**	**(3,632)**	**(1,095)**
Adjustments - Donated Items / Impairment / Gain on Asset disposal	96	86	(10)
Adjusted Surplus / (Deficit)	**(2,441)**	**(3,546)**	**(1,105)**

In Month Variance Overview
In month planned financial deficit for Sep-23 was **(£2. 44m)**.
The actual net expenditure reported was **(£3.55m)**, showing an adverse variance to the plan of **(£1.11m)** in month.

Income Variance
In M06, the total Patient and Other Income shows a favourable variance of **£1.99m** compared to the plan. Torbay Pharmaceutical operational income saw a favourable variance of **£0.24m** due to activity levels for the month. ASC Client Contribution was higher this month by **£0.47m** partially offset by increased expenditure for the period.

Patient block income is **£0.51m** higher than anticipated in month for the receipt of pay award funding. Other Income favorable variance of **£0.56m** is mainly for additional Educational funding received.

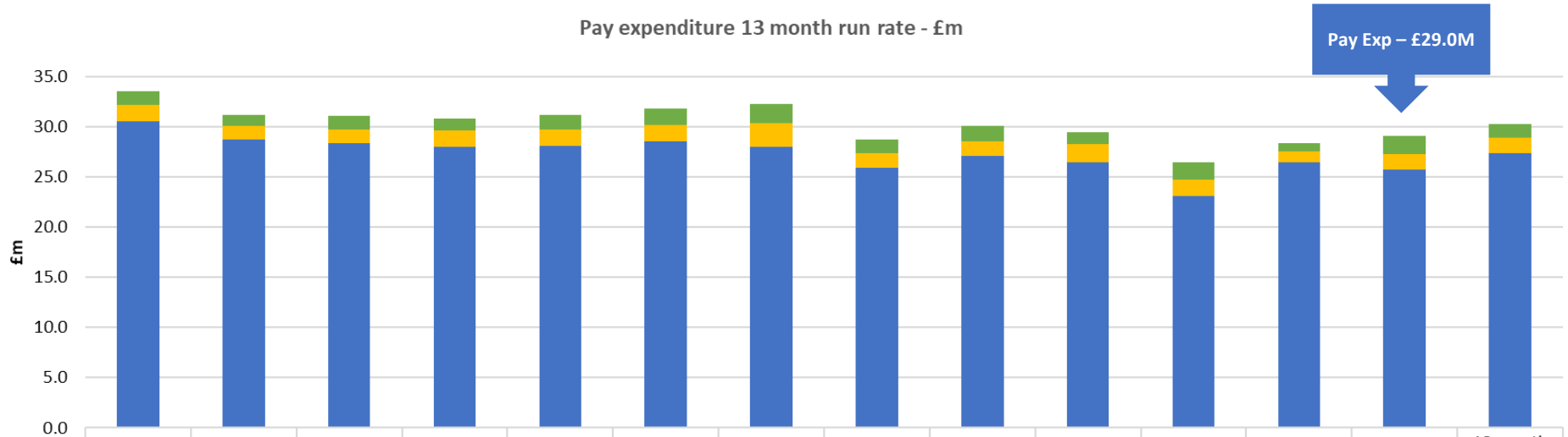
The **(£0.10m)** adverse variance in Other Patient Income mainly relates to provider-to-provider income and Private patient income.

Pay Variance
In M06, the cost bank and agency staff indicated adverse variance to plan of **(£1.42m)**, offsetting the favourable on substantive vacancies **(£0.891m)** and covering sickness. Substantive expenditure in month includes backdated medical pay award for the financial year. Please note, the CIP target has been phased more heavily from M06 onwards and is aligned with the workforce plan supporting the objective of maintaining a no workforce growth position.

Non-pay Variance
Total Non-Pay expenditure position was (**£2.56m)** adverse to plan. This is partial due to under-achievement CIP including ICS strategic CIP. Adult Social Care (ASC) and Continuing Health Care (CHC) is also showing an adverse variance to plan at £0.827m due to client complexity and increase in volume.

Pay Expenditure – Run Rate

Torbay and South Devon NHS Foundation Trust



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	13 month average
Agency	1.4	1.1	1.4	1.2	1.5	1.7	1.9	1.3	1.5	1.2	1.8	0.8	1.7	1.4
Bank	1.6	1.4	1.4	1.6	1.6	1.6	2.4	1.4	1.5	1.8	1.6	1.1	1.6	1.6
Substantive	30.6	28.7	28.3	28.0	28.1	28.6	28.0	25.9	27.1	26.5	23.1	26.5	25.7	27.3
Total	30.1	28.1	28.0	27.7	28.0	28.7	29.1	28.7	30.1	29.4	26.5	28.4	29.0	28.6

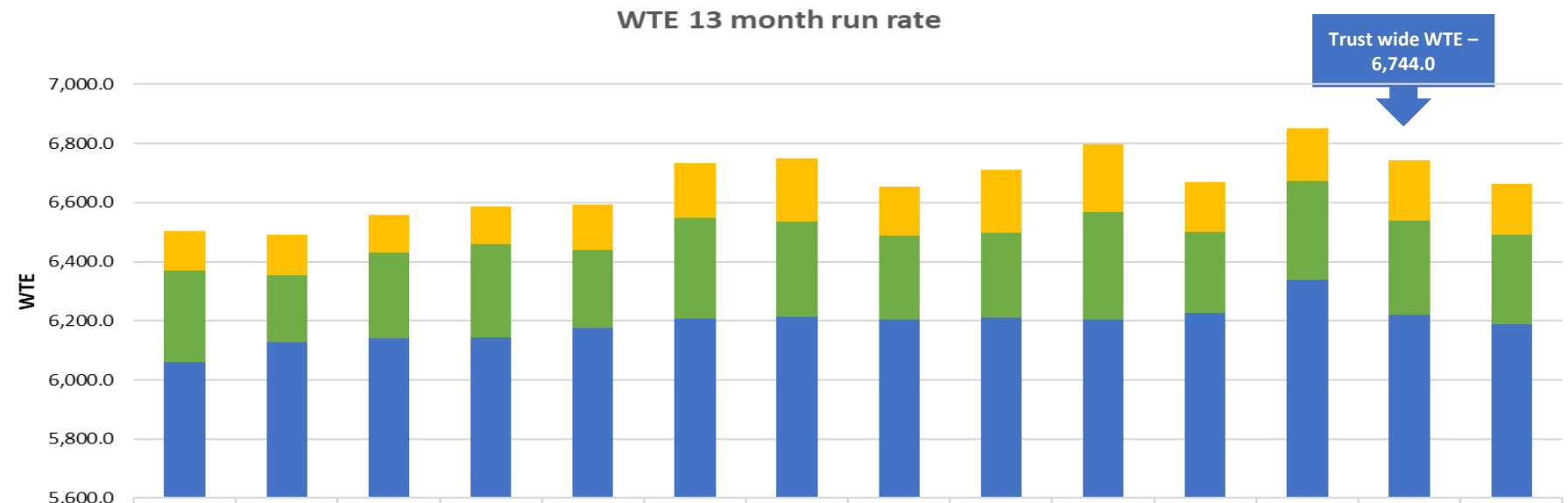
***Periods prior to Mar-23 have been inflated to 23/24 uplift to aid comparison in spend**

The graph above displays the run rate for overall pay expenditure over the previous 13 months* excluding technical adjustments, covering data that includes bank, agency, and substantive pay, along with any overtime hours worked. As at M06, there had been a slight increase in bank and agency usage due to ongoing industrial actions. The increase in substantive pay includes medical staff inflationary back-pay, partially attributed to the impact of industrial action.

At present, the ongoing run rate for bank and agency spending consistently exceeds **£1.0m**. This heightened level of expenditure is a direct response to the necessity of addressing staffing vacancies across the Trust and providing coverage for sickness leave. Moreover, this situation is exacerbated by the continued Industrial Actions.

It is imperative to emphasise that within the first six months of this fiscal year, almost 78.5% of the agency spending limit for the year, as stipulated by NHSE/I, has already been expended. Corrective measures has been implemented to control agency expenditure including aligning rostering system to budgeted establishment but more still need to done in reducing shift booking.

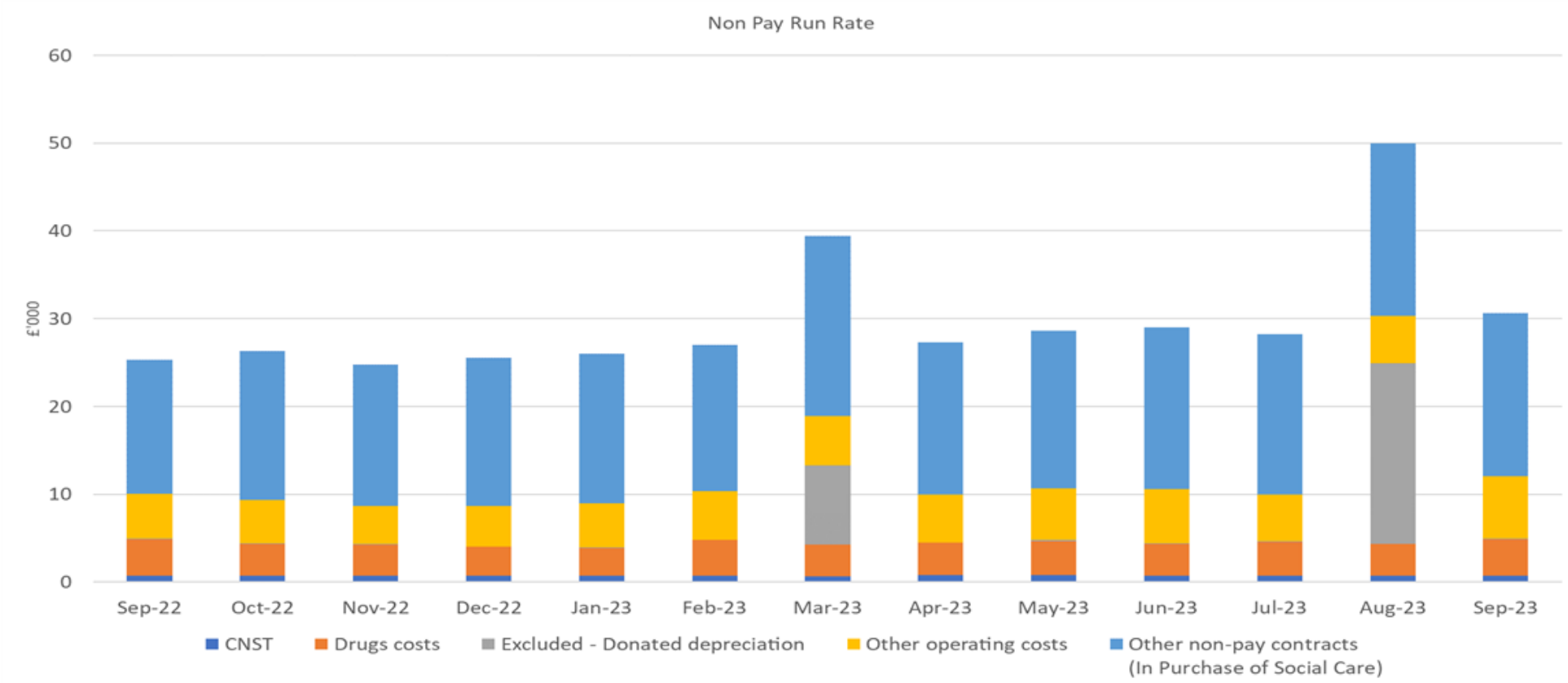
WTE – Run Rate



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	13 month average
Agency	135.1	134.3	126.9	125.9	151.9	185.3	213.2	166.0	212.6	229.5	168.3	176.4	205.8	171.6
Bank	308.9	229.3	292.2	317.4	265.8	340.6	321.4	282.0	289.0	362.7	273.2	337.2	318.1	302.9
Contracted	6,059.5	6,126.1	6,139.2	6,142.8	6,174.5	6,206.6	6,214.4	6,205.1	6,209.2	6,203.4	6,226.6	6,336.4	6,220.2	6,189.5
Total	6,503.5	6,489.7	6,558.3	6,586.1	6,592.3	6,732.6	6,748.9	6,653.1	6,710.8	6,795.5	6,668.0	6,850.0	6,744.0	6,664.1

The table provided a summary of the Whole-Time Equivalent (WTE) run rates observed over the course of the last 13 months. This summary includes data on bank, agency, and substantive WTE, and overtime. *It's important to note that the figures presented in this table may exhibit slight differences when compared to the information available in the workforce pack. These variations arise due to the inclusion of overtime data within this table* decreased from August due to the new cohort of rotational Medical and Dental staff that joined the Trust.

Non-Pay Expenditure – Run Rate



The year-to-date figures shows, the Non-Pay expenditure remained adverse to the plan, amounting to **(£25.30m)**. The adverse variance includes **(£20.50m)** impairment relating to the sale of Torbay Pharmaceuticals, while other adverse variances of **(£4.80m)** relate to continued escalation of Purchase of Social Care and Other non-pay operating expenses**.**

YTD Position By Care Group

NHS
Torbay and South Devon
NHS Foundation Trust

The table below provides a snapshot of our YTD financial position at the end of M06 at Care Group Level, with commentary on key variances that have material impact on our overall performance.

Care Groups	YTD Bud £000	YTD Act £000	YTD Var £000	R.A.G	Commentary
Children and Family Health Devon	0.29	1.01	0.71		Pay YTD is **£0.08m** under budget - includes **£0.50m** externally funded posts and agency costs supporting waiting list work and pilot schemes, offset by **£0.58m** vacancy slippage. Non pay **£2.24m** overspend is mainly for recharge of expenditure incurred (funded via external income) and un-planned risk share. Total Income is reported as a **£2.88m** above budgeted position, mainly to offset non pay and pay expenditure.
Families & Communities	(103.85)	(105.66)	(1.81)		YTD overspend is materially driven by overspends on ASC (volume and complexity) and Placed People (Torbay CHC - Dom Care and Nursing activity) packages of care of **£2.07m**. In addition to this there are pressures in Child Health (unachieved CIP & medical costs - junior doctor strikes) and Community Hospitals (unachieved CIP) of **£0.88m**. Other Divisions are reporting underspends of **£1.14m** for additional achievement of CIP and vacancy slippages.
Medicine and Urgent Care	(37.44)	(43.34)	(5.90)		The overspend to date is due to various factors including: Unachieved CIP across all divisions in the Care Group **£1.88m**, Ward pressures within the Older Peoples Care directorate **£0.71m**, Recovery areas that are still fully operational despite reduced budgets **£0.98m**, and medical cost pressures (includes Junior strikes and locum pressures) **£2.33m**.
Pharmacy Manufacturing Unit	0.04	(0.09)	(0.12)		Reported separately to this report
Planned Care and Surgery	(71.74)	(70.61)	1.14		YTD underspend of **£1.14m**, being pay overspends (excluding CIP) mainly locum, agency costs, industrial actions costs, offset with vacancies of **£0.6m**. Non pay under spends of **£1.7m** - mainly ESRF activity earlier in the year, Theatres consumables, Clinical Engineering, Labs, offset with overspends in Radiology outsourcing. Drugs overspend **£0.1m**. Other income **£0.3m** favourable for external funding received (offset mainly pay costs), CIP **£0.3m** favourable against plan.
Shared Corporate Services incl. Reserves & Other Income	190.12	193.70	3.58		Mainly for achievement of ESRF Productivity Growth CIP
Total	**(22.59)**	**(24.98)**	**(2.40)**		

ERF Income and Activity Position

Torbay and South Devon NHS Foundation Trust

Setting	YTD 19/20 Activity	YTD 23/24 Activity	YTD Var	YTD Var %	YTD 101% of 19/20 Income £'000	YTD 23/24 Income £'000	YTD Income Var £'000	YTD Income Var %
Day Cases	12,530	11,287	(1,243)	90%	10,366	10,496	131	101%
Electives	1,487	1,234	(253)	83%	5,941	4,731	(1,210)	80%
APC TOTAL	**14,017**	**12,521**	**(1,496)**	**89%**	**16,307**	**15,227**	**(1,080)**	**93%**
Firsts	36,754	35,821	(933)	97%	7,199	7,491	292	104%
First Procedures	7,758	8,948	1,190	115%	1,349	1,578	229	117%
Follow-Up Procedures	21,758	22,389	631	103%	3,088	3,399	311	110%
OPA TOTAL	**66,270**	**67,158**	**888**	**101%**	**11,636**	**12,468**	**832**	**107%**
Total ESRF Performance	**80,287**	**79,679**	**(608)**	**99%**	**27,943**	**27,694**	**(248)**	**99%**

The above shows the System target of 101% of 19/20 baseline. The original target for 23/24 was to meet 103% of the 19/20 baseline, however due to the Industrial Action, NHSE/I has reset the target to 101% taking into account its impact. The 19/20 baseline has been adjusted by 2.3% to reflect the increase to the tariff for the pay award, actuals have also been increased by 2.3% as this has now also been reflected in SUS.

The bottom-line position of 99% has decreased by 1% since last month, this position is not unexpected given that there has been further increases in cancelled appointments due to Industrial Action. The reason for activity being at 101% and finance at 99% is due to more electives and less outpatients being cancelled due to Industrial Action in the last couple of months and a change to the casemix of the electives being outsourced since M3.

Please note months 1 to 3 are based on 'Secondary Uses Services (SUS) freeze submission' and months 5 and 6 are based on 'Flex submission'. It is also worth noting that NHSE's data shows a better performance for providers due to unpunished phasing used, further work is required on finalising the baseline data with NHSE/I and ICB so the system can report an overall agreed position in the coming months based collective performance. In our YTD position £0.76m income clawback risk had been estimated and reported based the above performance.

Bed Utilisation

Torbay and South Devon NHS Foundation Trust

Point of Delivery	Sep 22 Act	Oct 22 Act	Nov 22 Act	Dec 22 Act	Jan 23 Act	Feb 23 Act	Mar 23 Act	Apr 23 Act	May 23 Act	Jun 23 Act	Jul 23 Act	Aug 23 Act	Sep 23 Act
Occupied Beds DGH	10,578	10,810	10,590	10,939	11,221	9,992	11,195	10,576	11,044	10,625	10,600	10,715	10,542
Available Beds DGH	11,109	11,388	10,994	11,375	11,598	10,376	11,559	11,092	11,460	11,125	11,385	11,342	10,999
Occupancy	95%	95%	96%	96%	97%	96%	97%	95%	96%	96%	93%	94%	96%

In M06, the overall bed occupancy for Acute beds is **96%**. Occupancy below **95%** is considered a minimum to support timely patient flow.

The increase in overall bed occupancy over the last two months has coincided with challenges in patient flow impacting an increase in Handover delays and levels of escalation.

Improvement initiatives are being supported by the Transformation and Improvement team reporting through the Unscheduled Care Board meeting every 2 weeks. The winter plan describes that actions being taken to prepare for winter and the expected increase in demand for admission to a hospital bed. In August, the “Discharge Ready” ward opened to cohort patients having No Criteria to reside, this is proving to be successful and reducing the length of stay for these patient and freeing up acute ward capacity earlier in the day.

The key areas of improvement are:

- Implementation and roll out of Virtual ward,
- Optimising Same Day Emergency Care (SDEC) to reduce number of patient transferred to main inpatient wards,
- Patient flow and inpatient ward delivery focusing on ward processes and timely discharge – key areas being the use of the discharge lounge, earlier in the day discharged (before noon **33%**) and to increase the number of patients discharged at weekends (Target **80%** of average weekday),
- Emergency Department clinical pathway improvement,
- Supporting out of hospital capacity including access to packages of care and intermediate care placement.
- Discharge Ready ward to support the focus on the number of patients identified as medically fit and having “No Criteria to Reside” in an acute hospital bed. In September the Trust reported 7.4**%** of occupied beds as "No Criteria to Reside". This is against the plan to deliver 5% by March 2024.

CIP Programme Delivery

Torbay and South Devon NHS Foundation Trust

Against our in-year CIP target of **£46.58m**, the number of schemes currently showing as green and having plans in place for delivery is totalling **£36.6m** for the whole year, leaving a remaining **£9.98m** still to be identified. Against the £36.6m approved schemes we are currently reporting a confirmed delivery of **£23.52m**, of which **£19.63m** (83%) being Recurrent schemes.

The schemes assessed as Green have delivered **£13.65m** to date, **£2.53m** more than the NHSE/I planned delivery of **£11.12m**.

Divisions and workstreams are working through 39 new ideas, of which 22 schemes have a high-level value of **£2.4m**.

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.

The Strategic ICB Collaborative schemes totalling **£10.5m** have been reduced in line with the latest forecast information provided by the ICB to **£4.7m** assessed as; **£0.2m** Green, **£0.2m** Amber and **£4.3m** Red by the PMO. We have route to cash meetings established to check and challenge the workstreams and to ensure TSD are engaged and pushing forward.

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 2023/24 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 **£52.8m** (non-risk-adjusted value).

2023/24 Scheme Development (£m)

12 Sep 2023		10 Oct 2023
91 Schemes £33.1	↑	113 Schemes £37.0
23 Schemes £5.2	↓	22 Schemes £2.4
20 Schemes £16.6	↓	17 Schemes £13.4
Total CIP Programme 134 Schemes £54.8	↓	Total CIP Programme 152 Schemes £52.8

Cash Position

Torbay and South Devon NHS Foundation Trust

Description	Bud £000	Act £000	Var £000
Opening Cash Balance	**14,961**	**34,734**	**19,773**
Capital Expenditure (Accruals Basis)	(22,241)	(18,388)	3,853
Capital Loan/PDC Drawn Down	14,786	9,108	(5,678)
Capital Loan Repayment Principal	(1,459)	(1,459)	0
Proceeds on Disposal of Assets	0	1	1
Movement in Capital Creditor	0	(8,730)	(8,730)
Other Capital-related Elements	317	(942)	(1,259)
Sub Total – Capital Related Elements	**(8,597)**	**(20,410)**	**(11,813)**
Cash Generated From Operations	(5,897)	(11,236)	(5,339)
Revenue PDC Drawn Down	22,587	16,975	(5,612)
Working Capital Movements – Debtors	(1,146)	5,019	6,165
Working Capital movements – Creditors	(34)	(996)	(962)
Net Interest	(1,259)	(418)	841
PDC Dividend Paid	(4,106)	(3,839)	267
Other Movements	(646)	(636)	10
Sub Total - Other Elements	**9,500**	**4,869**	**(4,631)**
Closing Cash Balance	**15,864**	**19,193**	**3,329**

- Planned opening balances will not therefore match actual opening balances. The opening cash balance was **£19.8m** higher than planned at 1st April due to higher level of capital creditor that had not been pay down as planned.
- Access to capital and revenue PDC support remains absolutely critical to the Trust's cashflow. FY23/24 planned total capital and revenue PDC funding is originally **£70.8m**, however this have now been revised to **£54.4m,** this reflects the delaying in completing of the national funded programme e.g. EPR and NHP and sale of TP. We will continue to revise this figure until the confirmation of the sale of TP and associated use of CDEL in year. Please refer to the supplementary Capital and Cash paper for further details.
- Capital-related cashflow is **£11.8m** adverse, largely due to the pay down of the capital creditor **£8.7m** during the beginning of the year. PDC capital drawdown is **£5.7m** behind plan partly due to in year capital expenditure being **£3.9m** behind plan.
- Cash generated from operations is **£5.4m** adverse due to adverse revenue position and Revenue PDC **£12.2m** support has been received in September 23.
- Debtor movement is **£6.2m** favourable, which is principally due to the 22/23 retrospective pay award **£12.1m** not being included in the initial cash plan. This is partly offset with an increase in ASC debtors.
- Creditor movement is **£1.0m** adverse. This principally due to the favourable debtor movement for the 22/23 pay award **£12.1m** matching debtors. This is partly offset with payroll creditors and provider to provider recharges as highlighted on the balance sheet.

Balance Sheet

Torbay and South Devon NHS Foundation Trust

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	11,715	13,599	1,884
Property, Plant & Equipment	259,039	211,092	(47,947)
On-Balance Sheet PFI	17,146	20,042	2,896
Right of Use assets	19,803	19,771	(32)
Other	1,843	1,607	(236)
Non-Current Assets Total	**309,546**	**266,112**	**(43,434)**
Cash & Cash Equivalents	15,865	19,192	3,327
Other Current Assets	41,807	65,762	23,955
Current Assets Total	**57,672**	**84,954**	**27,282**
Total Assets	**367,218**	**351,066**	**(16,152)**
Loan - DHSC ITFF	(2,917)	(2,918)	(1)
PFI and Leases	(4,157)	(4,329)	(172)
Trade and Other Payables	(52,819)	(70,198)	(17,379)
Other Current Liabilities	(5,267)	(10,888)	(5,621)
Current Liabilities Total	**(65,160)**	**(88,332)**	**(23,172)**
Net Current Assets/(liabilities)	**(7,488)**	**(3,378)**	**4,110**
Loan - DHSC ITFF	(20,833)	(20,937)	(104)
PFI and Leases	(30,835)	(31,011)	(176)
Other Non-Current Liabilities	(4,615)	(4,650)	(35)
Non-Current Liabilities Total	**(56,283)**	**(56,597)**	**(314)**
Total Assets Employed (Assets + Liabilities)	**245,775**	**206,137**	**(39,638)**
Reserves			
Public Dividend Capital	232,067	221,698	(10,369)
Revaluation	61,351	60,112	(1,239)
Income and Expenditure	(47,643)	(75,673)	(28,030)
Total	**245,775**	**206,137**	**(39,638)**

- Non-Current Assets are **£43.4m** lower than plan. This is largely due to a revenue impairment **£20.5m** and reclassification of an asset held for sale **£15.9m** to current assets. In addition, a FY22/23 property revaluation was lower than planned **£4.7m** and year to date capital expenditure **£3.9m** behind plan. This is partly offset by reduced depreciation **£1.7m** due to delays in bringing assets into service.
- Cash & Cash Equivalents is **£3.3m lower** than plan, please see separate commentary to the Cash Flow Statement.
- Other Current Assets are **£24.0m** higher than planned. This is mainly due to the assets held for sale **£17.0m,** ASC debtors **£1.6m** and accrued income **£2.8m** higher than planned
- Trade and Other Payables are **£17.4m** higher than plan. Principally this value is due to increased **£1.7m** capital creditors, **£6.0m** provider to provider charges such as CFHD, **£2.2m** general provisions and **£7.3m** payroll creditors.
- Other Current Liabilities are **£5.6m** higher than plan mainly due to income received a head of time and being deferred to match expenditure.
- PDC reserves are **£10.4m** lower than planned, due to Revenue PDC and Capital PDC support being drawn down later than planned.
- The Income and Expenditure reserve is **£28.0m** lower than plan, principally due to below-the-line asset impairment in 23/24 **£20.5m** and an impairment processed late in FY22/23.

Capital Position

Torbay and South Devon NHS Foundation Trust

	FY23/24 £m	FY24/25 £m	FY25/26 £m	FY26/27 £m	FY27/28 £m	Total £m
Net Applications of Funds						
IM&T Investment - exclude EPR	4.8	4.0	4.0	4.0	4.0	20.8
Digital EPR - Trust Funded Element - (i)	0.0	12.8	2.0	0.3	0.3	15.4
Estates Backlog Maintenance	4.6	4.0	4.0	4.0	4.0	20.6
Approved Estates Development Schemes	3.3	0.0	0.0	0.0	0.0	3.3
Medical Equipment	3.0	3.0	3.0	3.0	3.0	15.0
Torbay Pharmaceuticals - (ii)	2.3	0.0	0.0	0.0	0.0	2.3
Purchase of Dawlish Hospital	0.0	2.0	0.0	0.0	0.0	2.0
Other - Services Developments - TBC - (iii)	6.3	(5.8)	7.0	8.7	8.7	24.9
Prior Year Schemes	(0.1)	0.0	0.0	0.0	0.0	(0.1)
Sale of Assets - (iv)	(1.4)	0.0	0.0	0.0	0.0	(1.4)
Net ICB CDEL Total (v)	**22.8**	**20.0**	**20.0**	**20.0**	**20.0**	**102.8**
Source of Funds						
Revenue Surplus	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation / Amortisation	23.6	25.9	26.9	28.9	30.9	136.2
Repayment of ITFF Loan Funding	(2.9)	(2.9)	(2.4)	(2.4)	(2.4)	(13.0)
Repayment of Finance Leases	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(17.0)
Repayment of PFI Debt	(1.6)	(1.4)	(1.1)	(1.2)	(1.3)	(6.6)
Sub-Total	**15.7**	**18.2**	**20.0**	**21.9**	**23.8**	**99.6**
PDC Support Required (vii)	7.1	1.8	0.0	(1.9)	(3.8)	3.2
Grand Total	**22.8**	**20.0**	**20.0**	**20.0**	**20.0**	**102.8**

- M06 YTD expenditure is **£18.4m**
- Full year forecast **£48.3m** with no variance reported under national and System CDEL. However,
- Local position indicates an overspend on national CDEL with is mitigated by system CDEL budget mainly relates to Endoscopy Expansion project

	Capital Exp Programme Prior Mth £'000	Capital Exp F'cast M06 £'000	Var £'000	Capital Exp YTD M06 £'000
ICB CDEL	21,409	21,409	0	8,042
National CDEL	23,642	23,642	0	10,193
IFRS 16 CDEL	2,800	2,800	0	0
Other - Charitable Funds and PFI	479	479	0	197
Total	**48,330**	**48,330**	**0**	**18,432**

	Target March 2024	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Operational Plan trajectory Sept 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2844	3512	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	1137
Percentage of Ambulance handovers greater than 3 hours		23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	No trajectory
Total average time in ED (hours/minutes)		07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	No trajectory
ED attendances where visit time over 12 hours	0	906	988	939	1207	823	599	977	568	893	797	637	794	686	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	72%
% patient discharges pre-noon	33%		18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	12.0%	11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	7.5%
Elective recovery															
RTT 104 week wait incomplete pathway	0	50	47	34	29	22	14	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	813	829	822	923	708	462	183	166	167	123	129	156	187	111
RTT 65 week wait incomplete pathway	0	2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1189
RTT 52 week wait incomplete pathway	Reduction	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	Not set
Patient waits over 2.5 years	0	24	24	17	12	9	6	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	77.3%	75%
Number of patients waiting longer than 62 days for treatment	138	333	331	229	253	225	130	114	107	111	100	89	120	105	170

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - September 2023

	ISU	Target	13 month trend	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		5	0	0	2	3	1	2	1	1	1	4	1	1	9
Reported Incidents - Death	Trustwide	<1		1	1	0	0	4	0	1	0	1	1	0	2	0	4
Medication errors resulting in moderate harm	Trustwide	<1		0	0	1	0	0	0	0	0	1	2	2	2	0	7
Medication errors - Total reported incidents	Trustwide	N/A		64	36	44	48	47	44	62	68	72	76	70	74	58	418
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	3	1	2	0	3	1	0	0	1	0	0		1
Never Events	Trustwide	<1		0	1	0	0	0	2	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		2	3	0	6	13	3	13	5	7	8	11	7	7	45
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	1	0	0	2	1	2	1	0	0	6
Formal complaints - Number received	Trustwide	20		10	16	11	10	14	12	12	5	7	6	8	8	7	41
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.6%
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		112	110	108.9	108.7	106.8	104.2	101.9	99.9	98.1					98.1
Safer staffing - ICO - Day time	Trustwide	90% - 110%		96.4%	99.1%	99.4%	91.6%	92.1%	91.3%	93.1%	92.4%	96.0%	100.1%	96.0%	97.6%	98.1%	98.1%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		85.6%	88.8%	86.4%	87.4%	87.9%	87.0%	88.4%	91.3%	90.0%	89.0%	90.0%	88.7%	90.1%	90.1%
Infection Control - Bed Closures - (Acute bed days in month)	Trustwide	<100		132	42	156	786	339	254	164	217	120	99	24	522	231	1213
Hand Hygiene	Trustwide	>95%		96.6%	94.9%	96.2%	91.2%	94.0%	92.1%	91.3%	92.5%	92.9%	91.3%	87.7%	92.6%	87.9%	90.9%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		6	3	2	1	8	2	2	4	7	7	4	4	6	14
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			3	2	0	1	7	1	1	3	4	4	2	0	5	18
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			3	1	2	0	1	1	1	1	3	3	2	4	1	14
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	53.8%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%	73.3%	46.9%
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		21821	20806	20257	21452	20030	20048	19979	19618	19609	18738	18842	19582	20140	20140
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.7%	5.7%	5.6%	5.6%	4.7%	5.7%	5.6%	5.0%	5.3%	5.3%	5.2%	5.2%	5.2%	5.2%
Appraisal Completeness	Trustwide	>90%		75.8%	76.6%	77.6%	76.7%	77.7%	76.7%	76.9%	77.9%	78.1%	78.1%	78.1%	79.9%	78.9%	78.9%
Mandatory Training Compliance	Trustwide	>85%		88.7%	88.6%	89.1%	89.7%	89.9%	90.1%	90.4%	90.7%	91.2%	91.7%	91.5%	91.8%	91.6%	91.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.9%	13.7%	13.7%	13.5%	13.3%	13.1%	12.8%	12.9%	12.7%	12.5%	12.7%	12.5%		0.0%

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	ISU	Target	13 month trend	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%		6.8%			6.5%			6.5%			5.5%				
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		737	751	735	756	755	781	814	784	804	817	823	852		
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		205	277	297	299	318	307	298	288	322	325	308	312	335	1555
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		197	193	203	208	198	200	251	224	218	225	278	226	199	1370
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		20	26	27	40	34	34	30	26	34	36	37	45		349
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		85.0%	100.0%	74.1%	77.5%	79.4%	94.1%	90.0%	92.3%	88.2%	88.9%	97.3%	95.6%		81.7%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				196	182	177	171	160	138	162	151	124	126		1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				86.2%	84.6%	92.7%	83.3%	86.3%	86.2%	85.8%	85.4%	85.5%	88.1%		83.1%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		32.6	27.2	29.9	32.6	32.6	28.5	29.9	32.6	27.2	24.5	27.2	16.3	24.5	16.3
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		931.5	861.5	901.9	915.4	840	802.3	826.5	805	748.5	729.6	729.6	735	740.4	735.0
Proportion of clients receiving direct payments	Trustwide	25%		20.4%	20.3%	20.2%	20.3%	20.0%	20.2%	19.5%	20.1%	20.1%	20.0%	20.6%	21.1%	20.7%	21.1%
% reablement episodes not followed by long term SC support	Trustwide	83%		85.2%	86.0%	85.5%	85.4%	86.6%	86.4%	86.4%	85.3%	88.3%	88.9%	87.7%	87.9%	88.3%	87.9%

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	ISU	Target	13 month trend	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		45.3%	63.8%	58.4%	67.4%	76.3%	82.6%	76.0%	55.9%	74.1%	76.3%	68.6%	69.5%	70.7%	70.7%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		79.1%	87.7%	82.8%	100.0%	93.5%	97.6%	88.9%	87.9%	76.7%	69.6%	61.5%	83.6%	100.0%	100.0%
Cancer - 28 day faster diagnosis standard	Trustwide	75%		70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	77.3%	77.3%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		92.8%	96.4%	89.0%	98.3%	95.5%	98.3%	95.9%	89.7%	92.3%	93.3%	95.6%	97.9%	90.7%	90.7%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		98.7%	100.0%	90.4%	98.6%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		92.2%	94.4%	98.0%	100.0%	85.7%	100.0%	86.9%	100.0%	96.9%	80.8%	85.5%	93.3%	91.1%	91.1%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		96.8%	89.7%	86.8%	89.7%	80.0%	96.2%	83.3%	88.5%	87.5%	89.7%	88.9%	92.3%	100.0%	100.0%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		60.8%	64.2%	54.5%	63.1%	47.2%	47.1%	63.2%	66.8%	54.7%	65.6%	67.4%	78.6%	70.7%	70.7%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		90.9%	100.0%	81.0%	76.9%	100.0%	100.0%	72.7%	100.0%	100.0%	77.4%	80.0%	57.1%	33.3%	33.3%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide	20		43	71	62	69	68	53	24	20	11	7	10	11	14	14
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		42.5%	45.5%	45.5%	43.3%	43.9%	44.3%	48.1%	49.7%	49.8%	51.2%	53.1%	52.0%	54.1%	54.1%
RTT 65 week wait incomplete pathway	Trustwide	1091		2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1161
RTT 78 week wait incomplete pathway	Trustwide	178		813	829	822	923	708	462	183	166	167	123	129	156	187	187
RTT 104 week wait incomplete pathway	Trustwide	0		50	47	34	29	22	14	0	0	0	0	0	0	0	0
On the day cancellations for elective operations	Trustwide	<0.8%		1.4%	1.7%	1.5%	2.1%	1.4%	1.5%	1.5%	0.8%	1.4%	1.8%	1.4%	1.6%	1.7%	1.5%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		8	7	15	6	11	10	7	7	10	14	13	23	37	104
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.8%	n/a	16.6%	16.1%	16.5%	15.3%	14.6%	15.8%	15.2%	15.0%	15.3%	15.9%		
Bed Occupancy	Acute	90.0%		92.3%	92.3%	95.2%	94.9%	96.3%	96.2%	96.3%	95.3%	96.4%	95.5%	93.1%	94.0%	96.0%	95.1%
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	
% patient discharges pre-noon	Acute	33%								19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	
% patient discharges pre-5pm	Acute	75%								67.3%	69.8%	66.7%	67.7%	67.9%	70.6%	70.9%	
Number of patients >7 days LoS (daily average)	Trustwide			184.9	177.0	162.0	172.6	183.5	166.1	167.0	154.2	159.8	156.2	129.9	156.0	159.8	152.7
Number of extended stay patients >21 days (daily average)	Trustwide			49.2	49.8	32.0	42.3	57.1	40.7	38.6	39.3	33.2	35.2	30.6	35.9	38.3	35.4

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	ISU	Target	13 month trend	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide			1012	1208	1112	1232	865	534	1043	598	1025	1002	936	1098	1346	6005
Ambulance handover delays > 60 minutes	Trustwide	0		764	933	787	983	623	263	687	277	595	615	490	629	907	3513
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	68.4%
ED - patients with >12 hour visit time pathway	Trustwide			906	988	939	1207	823	599	977	568	893	797	637	794	686	4375
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				37%	39%	31%	46%	44%	41%	52%	53%	55%	59%	61%	71%	71%
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								40%	44%	41%	40%	29%	26%	28%	29%	29%
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				05:21	05:14	06:05	05:02	04:53	05:08	04:24	04:42	04:22	04:17	04:03	03:59	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				14:06	13:14	16:05	13:42	10:06	12:47	09:10	11:15	10:55	08:47	11:19	09:53	
Diagnostic tests longer than the 6 week standard	Trustwide	15%		34.9%	32.4%	30.1%	29.0%	34.0%	26.1%	29.7%	29.8%	27.7%	24.3%	25.5%	29.1%	31.5%	31.5%
Dementia - Find - monthly report	Trustwide	>90%		94.1%	87.2%	93.0%	91.6%	87.9%	84.5%	87.1%	83.6%	90.7%	85.2%	86.1%	87.8%	81.7%	81.7%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%			69.1%		48.9%		65.7%	58.1%	65.0%	61.5%	71.7%	70.3%	73.0%	78.3%	70.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%			47.4%		41.5%		45.1%	39.4%	49.1%	55.5%	52.7%	58.5%	46.2%	62.4%	54.2%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		59.0%	60.0%	62.0%	68.0%	73.9%	69.2%	62.8%	67.7%	64.4%	63.7%	61.9%	71.6%	73.9%	

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	ISU	Target	13 month trend	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-5783	-7140	-10433	-13434	-16118	-19884	-21358	-394	-342	-761	-1254	-3116	-5341	
Agency - Variance to NHSI cap	Trustwide			-2.00%	-1.90%	1.90%	-1.80%	-1.80%	-1.90%	-1.90%							
Agency - Spend in month against budget value	Trustwide										38.22%	55.00%	-22.78%	141.06%	155.12%	159.29%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-4403	-4872	-5005	-5874	-5328	-5512	-3390	-449	17	2478	2486	2529	2529	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			975	1988	2787	3280	4076	944	-18162	-993	3619	1616	-515	1517	3267	
Distance from NHSI Control total (£'000's)	Trustwide			-4014	-5022	-7421	-9995	-12182	-15796	-17186	22	307	300	300	-1293	2389	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																	
Outpatients - New	Trustwide			0.2%	-11.7%	3.6%	-2.0%	-5.2%	-0.6%	16.1%	-10.0%	7.7%	11.2%	-5.6%	7.0%	14.8%	3.9%
Outpatients - Follow ups	Trustwide			-0.8%	-10.1%	4.4%	-4.1%	-6.9%	-2.4%	9.0%	-8.0%	5.7%	9.0%	-3.0%	7.2%	-1.2%	2.2%
Daycase	Trustwide			3.2%	-4.6%	-3.0%	-5.5%	-1.7%	5.1%	21.7%	-12.8%	-5.5%	8.4%	-4.0%	-2.0%	3.1%	-2.0%
Inpatients	Trustwide			9.6%	-16.3%	-19.5%	-21.4%	-18.1%	-16.4%	42.0%	-16.2%	-1.3%	-1.4%	-20.8%	0.7%	-0.4%	-7.9%
Non elective	Trustwide			-7.1%	-7.0%	-12.7%	-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-8.9%	0.4%	0.4%	12.3%	9.1%	0.5%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			0	0	0	0	0	0	0	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
Intermediate Care GP Referrals	Trustwide			95	94	78	80	78	75	74	64	94	87	89	88	94	
Average length of Intermediate Care episode	Trustwide			0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	

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Report to the Trust Board of Directors			
Report title: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			Meeting Date: 25th October 2023
Report appendix	No appendices		
Report sponsor	Interim Medical Director		
Report author	Dr Claire Blandford, GOSW		
Report provenance			
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training		

Summary of key elements

Strategic objectives supported by this report

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

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

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

BAF Objective 1: Quality and Patient Experience

External standards affected by this report and associated risks

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

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Report title: Guardian of Safe Working Hours – Doctors and Dentists in training	Meeting date: 25th October 2023
Report sponsor	Interim Medical Director
Report author	Dr Claire Blandford - GOSW

1. Executive Summary

The following report concerns the time period of 11th July 2023 up to the 5th October 2023 based on the Exception Reports submitted by the Junior Doctor workforce.

There remain significant cohorts of Junior Doctors who are not represented in Exception Reports; this missing data makes spotting patterns difficult despite high efforts to encourage them to engage.

2. Introduction

- In July 2019 an agreement was reached between NHS Employers, the BMA and Department of Health on the amendments to the 2016 terms and conditions for doctors in training. The agreement covers the period from 1 April 2019 to 31 March 2023.

- The following report aims to ensure Junior Doctors are working contracts compatible with the Junior Doctor Terms and Conditions of Service 2016, that are sustainable and fair and that they are able to claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities or complete career enhancing objectives.

3. Exception Reports

There have been 60 Exception Reports in the period 11th July 2023 up 5th October 2023. This is a decrease of 6 on the number of exception reports from the previous quarter.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Anaesthetics	0	0	0	
Acute medicine	2	2	0	
General Medicine	38	31	7	
General Surgery	1	1	0	

OMFS	1	0	1	
Respiratory	8	0	8	
Surgical Specialities	2	2	0	
Geriatric Medicine	5	4	1	
T&O	3	1	2	
Total	60	41	19	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	28
F2	13
CT1-3	19
ST 4-9	0
Total	60

Table 3 – Nature of Exception

Additional Hours	59
Pattern of Work	1

Table 4 – Outcome of Exceptions

TOIL	18
Payment	32
Work Schedule Review	0
Agreed no further action required	11

4. Comment on Exception Reports

Abbreviations used: PGDiT (post graduate doctor in training), LED (locally employed doctors), ER (exception reports), TOIL (time off in lieu) JDRC (junior doctors representative committee).

This time period straddles PGDiT/LED induction at the start of August. The number of exception reports is slightly lower than previous report. This could potentially be due to initial reticence in a new post to submit exception reports, PGDiT'/LEDs perhaps feeling they are 'settling in' and/or potential practical issues in gaining timely access to exception

reporting software systems upon joining the organisation. However, I wouldn't say this was a worrying level of reduction in the number of ERs.

I presented at both PGDiT/ LED inductions and highlighted that as a trust we were very supportive of exception reporting and wanted to ensure patient safety was paramount. I also sought to clarify for the junior doctor body that the exception reporting system is not the mechanism whereby if there is an immediate safety concern that escalation and help for this should be sought – that is the responsibility of the doctor raising the concern to communicate, verbally, with the senior clinician responsible for that area who will then take steps to resolve the situation. The purpose of the ER in this situation is as a record of what has happened and what action was taken so that this can be noted and any trends may be assessed / future preventative actions could be taken/ support for the doctor involved as needed. No immediate safety concern reports received this review period.

Once again, the largest clinical area represented by ERs is general medicine with the highest group of submissions from the F1 grade. I notice an increased proportion of ERs in this period have been resolved with TOIL rather than payment as compared to previous report periods.

I am unable to identify any specific areas where the pattern of ER submissions is concerning for the trust.

5. Rota Reviews

No formal rota reviews undertaken.
No specific rotas regarding oncall work have been highlighted as concerns by the JDRC to me at guardian oversight meetings.

The delays in releasing the generic and personal work schedules that affected the junior doctor body last June caused significant concern and stress to our junior colleagues, many of whom were joining the trust for the first time. The junior doctor contract specifies generic work schedules should be provided by the employing organisation at least eight weeks in advance. I know the various teams involved worked as hard as they could to resolve this and the reasons for the delay seemed to be multifactorial. However, I would like to highlight this event to the board due to the distress that was caused and the resultant negative perception of the trust that some individuals felt as a result.

A concern that has been passed to me that the minimum staffing levels of junior doctors allocated to George Earle ward should be increased from the current 3 to 4. This concern has been raised by the consultant body working on that ward as well as the junior doctors in that area via the JDRC. The work load is recognised to be very high in that area due to higher acuity, higher numbers of discharges and the direct to stroke unit admissions policy. The junior doctors are frequently staying later than the scheduled finish times on normal working days in order to manage the high work load and I am seeing this reflected in some exception reports. The way the ward works with consultants reviewing any new direct to ward admissions in the afternoon also reduces pressure on the acute medical take team but having an extra junior doctor in this environment would improve the ability to manage these direct to ward admissions effectively. The consultant body have observed that when a 4th junior doctor has been available on the ward what a significant difference it makes.

I have fed this back to the senior leadership team so that they are aware of this concern and can work to develop an effective staffing model going forward. I will continue to review exception reports from this area.

6. Fines

No fines invoked in this period

7. Qualitative Information

Incorporated into other sections of this report

8. Summary

A stable time period with no concerning trends to notify the board of.

In addition since the last board report, I have worked with HR to update the MD1 Exception reporting policy. This reflects a new transition from paper based claim forms to digital claiming via TempRE for any ERs closed with payment. All PGDiT's have been contacted with details of the new policy and provided with links for registering for TempRE and technical support. The update also clarified that responding to exception reports is the responsibility of either the PGDiT/LED's named clinical or educational supervisor. The doctor should nominate whichever one they feel is the most appropriate depending on the location of work of their supervisors and the environment that the ER occurred within when submitting their ER. This has always been the case however the policy wording was updated to provide greater clarity. The JDRC approved the policy amendments before release.

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Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1July 2023 – 30 September 2023)			Meeting date: 25th October 2023
Report appendix:	2023-2025 Operational and Strategic plan – Appendix 1		
Report sponsor:	Chief Nursing Officer		
Report author:	Director of Midwifery and Gynaecology Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance:	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity & Neonatal System (LMNS). It is also required as part of the maternity reporting framework for NHS England (NHSE)		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to provide assurance to the Board around key aspects of the maternity safety agenda, specifically relating to: • Setting out the Trust position in relation to perinatal mortality and morbidity. To update the Board on any areas of risk with compliance for Maternity Incentive Scheme (MIS) in year 5 • To provide an update on progress following the Insights visit in July 2023. • To provide an overview of the findings of the Case Study into retention of midwives conducted by Kings College London research midwives.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	• Note the progress and compliance position regarding the priority areas. • Note the key quality and safety issues identified in the report. • Note the potential areas of risk and mitigation to full compliance with Maternity Incentive Scheme year 5. • Note the plan to present an overview of maternity services to the Board of Governors in December 2023. • Note the intention to utilise the findings of the case study into retention of midwives at system and regional level.		
Summary of key elements			

How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report describes the quality of maternity care that is accessible and available to the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitors this care.
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant people and babies.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People
Risk: Risk ID: *As appropriate*	*NA*
External standards affected by this report and associated risks	NHS England licence and regulations National policy, guidance

Report sponsor	Chief Nurse
Report author	Director of Midwifery and Gynaecology Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Deputy Head of Midwifery

1.0 Introduction

Safety, quality and experience has always been a priority for the maternity and neonatal services at Torbay and South Devon NHS Foundation Trust. The publication of both the Ockenden Review of Maternity Care at Shrewsbury and Telford, (December 2020 and March 2022) as well as the East Kent report 'Reading the Signals '(October 2022) provides all maternity and neonatal providers and commissioners with evidence of the devastating effects and consequences that poor culture and governance can have on families. NHS England & Improvement have set out clear expectations around governance and safety in response to these reports for all providers of maternity care.

This quarterly report will be constructed to meet the recommendations within the Ockenden reports as well as addressing the reporting requirements for Maternity Incentive Scheme (MIS). We plan for this to be an iterative process, firstly as the Board and maternity services work to review, amend and strengthen existing reporting mechanisms, and secondly as NHS England & Improvement (NHSEI) provide additional resources to support Trusts in enhancing their safety culture. It will also provide a mechanism to evidence progress with the three-year Single Delivery plan for Perinatal care.

This quarterly report will look back at the period 1 July 2023 – 30 September 2023 (Q2)

2.0 Review and monitoring of safety within maternity services

2.1 National Maternity Assurance Position – The Single Delivery Plan

2.1.1 On 30 March 2023 NHS England published a three-year single delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden (2020/ 2022) and Dr Bill Kirkup (2022), the plan brings together the key objective's services are asked to deliver against over the next three years.

The report sets out the 12 priority actions for trusts and systems for the next three years, across four themes or pillars.

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

2.1.2 Devon LMNS has developed a maternity strategy that aligns to the three-year Delivery Plan. This was devised in conjunction with the Directors/Heads of Midwifery of

the three provider Trusts, the Senior LMNS team as well as by representatives of the MVNP.

The Director of Midwifery has written the 2023-2025 operational and strategic plan based on the Devon maternity strategy. This plan is included in full as **appendix 1**.

2.1.3 There was an "Insights "visit with regional and system teams on July 7th, 2023. This was an opportunity to demonstrate progress as well as highlight challenges and opportunities. A summary of the key findings is noted below.

- Good progress noted against recommendations from 2022 visit- all elements within control of the maternity service have been prioritised for improvement.
- Preparatory work for the visit was exceptional and the team were incredibly welcoming and open.
- **Assessment of starting position against the Three-Year Delivery Plan was positive with lots of good practise noted.**
    - Excellent midwifery retention programme, especially for newly qualified midwives
    - Clear focus on quality improvement & safe services, with excellent board level engagement
    - Sustained implementation of maternity transformation initiatives
- **Recommendations relating to the Three-Year Delivery Plan can be summarised in the following themes:**
    - Further development of SystmOne to support accessibility and monitoring of data & outcomes.
    - Enhanced support for staff groups such as obstetricians and long-standing members of midwifery team
    - Enhancing personalised care- including electronic patient record options, accessible information, and inclusion of the MNVP in governance processes
- **Significant challenges were noted that impact the smooth running of the maternity & neonatal units including:**
    - Single rota across obstetrics & gynaecology
    - Access to theatres, noting doubling of elective section rate without an increase in theatre capacity (estates & staffing)
    - Ockenden requirement for verbal support from on call consultants during neonatal resuscitation (whilst travelling to attend)
    - Uncertain impact of the paediatric acute sustainability programme on neonatal services

The final report from Devon LMNS has been delayed due to significant capacity issues within their team. This is anticipated in early November.

2.2 Perinatal Clinical Quality Surveillance Model

As part of the Ockenden Review and the NHSEI 12 urgent actions, a model has been proposed to improve oversight of safety metrics within Maternity and Neonatal Services. The Perinatal Clinical Quality Surveillance (PCQS) Model is based on three principles, with principle one relating to trust level, principle two at system level and principle three at regional level. Principle one (Table 1) focuses on strengthening trust level oversight for quality, with 6 requirements. The Trust is able to demonstrate full compliance in all areas of principle one.

Table 1: Perinatal Clinical Quality Surveillance Model (PCQS)

PCQS Requirements
1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMNS, in addition to reporting as required to HSIB.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMNS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model

Trust Board Reporting – Quality and Safety within Maternity Services

Table 2 sets out the mandated reporting framework for maternity quality and safety metrics (The Committee will note that quality and safety metrics are also reported on a monthly basis through the Board IPR.)

Table 2: PCQS Minimum Dataset Information Summary Q2 2023

	July 2023	**August 2023**	**September 2023**
Findings of completed review of all perinatal deaths using the real time data monitoring tool (see 2.3 b for full details)	None Undertaken	None Undertaken	None Undertaken
Findings of review all cases eligible for referral to MNSI (formally HSIB). **We have included as appendix, the LASER Templates developed for families and staff to demonstrate the incident recommendations and learning (appendix 1)**	No eligible cases.	Please see appendix 2 for details of learning from finalised cases	No eligible cases.
Report on: The number of incidents logged graded as moderate or above and what actions are being taken	**1 Moderate** Neonatal readmission for severe hypoglycaemia. 72 hr report completed, SI investigation in progress.	**2 Moderate** Second Twin born in poor condition following breech extraction and transferred to tertiary hospital. 72 hr report completed Referred to HSIB Woman with gall stones rapidly deteriorated into ketoacidosis requiring HDU care	**1 Moderate** Baby born in poor condition following SVD and transferred to tertiary hospital. 72 hr report completed Referred to HSIB
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	**Training –** 93% compliance	**Training –** 94% compliance	**Training** – 95% compliance
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	**Staffing** Full details in section 3	**Staffing** Full details in section 3	**Staffing** Full details in section 3
Service User Voice feedback	Feedback mechanisms in place. Feedback shared with teams. Formal feedback via Trust Monthly feedback and engagement meetings	Feedback mechanisms in place. Feedback shared with teams. Formal feedback via Trust Monthly feedback and engagement meetings	Feedback mechanisms in place. Feedback shared with teams. Formal feedback via Trust Monthly feedback and engagement meetings
Staff feedback from frontline champions and walk-about	Completed- detail included within this paper	Completed- detail included within this paper	Completed- detail included within this paper
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	None	HSIB referral as detailed above. Awaiting staff interviews	HSIB referral as detailed above, awaiting decision if case will progress to full investigation.
Coroner Reg 28 made directly to Trust	1 x NND reported to Coroner TOP at 20+1 born with signs of life and died at approx. 20 minutes old.	Nil	Nil

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	59%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	See HEE update in 3.0

Serious Adverse Events

2.3 Perinatal Mortality Review Tool (PMRT)

The PMRT tool is now embedded in practice following its introduction in 2018. It has been used at the local multi-disciplinary case reviews to review the care and draft reports. There are clear reporting timescales.

The maternity service writes to all parents to advise them that a review will take place. They are given the opportunity to provide a perspective about their care and raise any questions that they have. All of the families have provided feedback. We have now established a process of inviting external reviewers to the PMRT reviews as set out in the standards.

(a) PMRT – Notifications of perinatal loss

During July – September 2023 we had one case that met the PMRT criteria.

- A mother who when seeking a termination was found to have had a late fetal loss. The baby was delivered at 22+2 weeks gestation.

(b) PMRT – Completed Reviews

During Q2 no PMRT reviews were undertaken.

2.4 Maternity and Newborn Safety Investigation Special Health Authority (MNSI) – Formerly HSIB

In September 2023 the maternity investigations that were formerly conducted by HSIB now come under the new Maternity and Newborn Safety Investigation Special Health Authority (MNSI).

2.4.1 Referrals to MNSI

In Q2 two new cases were reported to MNSI.

In August there was the case of a second twin who was born in poor condition following a breech extraction. The baby required therapeutic cooling at a tertiary centre.

In September a baby was born in poor condition following a spontaneous vaginal birth and was transferred to a tertiary centre for therapeutic cooling. This case is still under consideration by MNSI.

2.4.2 Ongoing MNSI Cases

There are no ongoing MNSI cases.

We have also provided input to a MNSI case reported by RDUH concerning a neonatal death following a vaginal delivery of a woman who received her antenatal care with Torbay and South Devon NHS FT but gave birth at RDUH (East).

We are awaiting draft reports for both these cases for review and sign off.

2.4.3. Finalised investigation reports from MNSI

In Q2 one finalised report were completed and received from MNSI. The learning from these reports have been circulated via the Maternity Safety and Learning newsletter and summarised in a poster in all clinical area entitled, Learning from Adverse Serious Event Reviews (LASER). **(Appendix 2)**

Additionally, copies of the final MNSI report and LASER have been circulated for staff learning in all of the Maternity clinical areas and via the clinical governance newsletter.

2.4.4 Quarterly Engagement Meeting with South West Maternity Investigation Team

The Quarterly engagement meetings are no longer being conducted by the South West Investigation team. We have set up monthly informal catch ups to continue to ensure progress of cases and maintain the flow of information between the trust and MNSI.

2.5 Safety Improvement

*2.5.*1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP) including PERI Prem

The West of England and Health Innovation South West have come together to develop a South West-wide Deterioration Community of Practice. The aim of this project is to provide a space in which organisations can work collaboratively, to learn from each other and share feedback during the active stage of the programme.

A MatNeoSIP “Deterioration Community of Practice” event was held on 12 July 2023. The event focussed on recognition and management of deterioration with the aim of supporting planning and implementation within units, utilising a Quality Improvement methodology. There was an emphasis on teamwork and the development of a readiness checklist, and a national update was provided.

The event highlighted that the various organisations within the community are at differing degrees of readiness and are encountering a variety of barriers and enablers.

The PERIPrem project (Perinatal Excellence to Reduce Injury in Premature Birth) is now managed within the SW ODN region under the MatNeoSIP optimisation workstream. The most recent ‘Share & Learn’ event was held on 3 September 2023 and centred on normothermia (maintenance of a normal core body temperature) in the new-born infant. Organisations shared their data and the challenges and successes that they have encountered in this element of the PERIPrem work, in order to aid system-wide learning.

2.5.2 Saving Babies Lives Care Bundle V3-

Saving Babies Lives Care Bundle Version 3 (SBLCB v3) was launched in May 2023. This continues to build on the existing bundle expanding each element, and adds a sixth element (management of pre-existing diabetes in pregnancy) for implementation. Version 3 is required to be fully implemented by March 2024

We are required to use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB.

A summary of the maternity service's areas of current position against the 6 elements is provided in the table 3, including areas of risk, mitigations and potential investment/actions required: (Table 3)

(Table 3) Element	Areas of risk	Action required
Element 1: **Reducing Smoking in Pregnancy** Currently Torbay & South Devon maternity service runs a fully in-house tobacco dependence treatment service.	Currently we hold separate telephone booking appointment followed by face-to-face appointment. This can impact on data accuracy and ability to confirm smoking status with CO reading.	Explore combined booking clinics by MSW and Community midwives.
	Data recorded on 2 digital platforms which don't interface, impacting on data required for outcome indicator	Team have requested that data from second digital platform is reported to them monthly
Element 2: Fetal Growth	BP recordings should be taken with a digital monitor. Currently manual monitors used in clinic and community	Cost up and purchase digital BP monitors for community & clinic. To be funded from MIS rebate.
	Further expansion of capacity required for women needing growth scans.	Review of sonography staffing and skills required & consideration of revisiting bid for fourth scan room
Element 3:	Fully compliant	

Raising awareness of reduced fetal movements		
Element 4: Effective fetal monitoring during labour	Fully compliant	
Element 5: Reducing preterm births and optimising perinatal care	Preterm Birth Midwife and Perinatal Pathway Optimisation Lead should be in post.	Specialist Preterm birth Midwife currently in post (0.4WTE) but funding only provided until March 2024 at present. Consideration of permanent funding for Preterm Birth Specialist role as well as reviewing responsibility and role of Perinatal Optimisation Lead
Element 6: (NEW) Management of pre-existing diabetes in pregnancy	Women with pre-existing diabetes should be seen in one stop multi-disciplinary clinic which includes a diabetes midwife – there is currently no diabetes midwife.	Consideration of creation of specialist Diabetes Midwife role from within antenatal clinic establishment.
	Agreed pathway which provides holistic care planning & pathway for provision of additional public health support – fully holistic care planning is not currently provided.	Joint working needs to be planned to enable attendance in the clinic of Public Health midwife.
	Agreed pathway for management of women with DKA (Diabetic Ketoacidosis), including clear escalation pathway	Trust wide policy for DKA in place. Maternity specific policy to be written.

There has been a continued improvement in our CO compliance with an ongoing significant 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 6.6% which is below the national average of around 8.8%
Reducing smoking in pregnancy is a common goal across the whole of the Saving Babies Lives Care Bundle.

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 recommended user average and are one of the Top 10 Trusts in the country for detection of small babies. The Trust detection rate was 64.3% compared to the National average of 42.6%. This links with Element 2 of the Saving Babies Lives Care Bundle.

2.5.3 Stillbirth

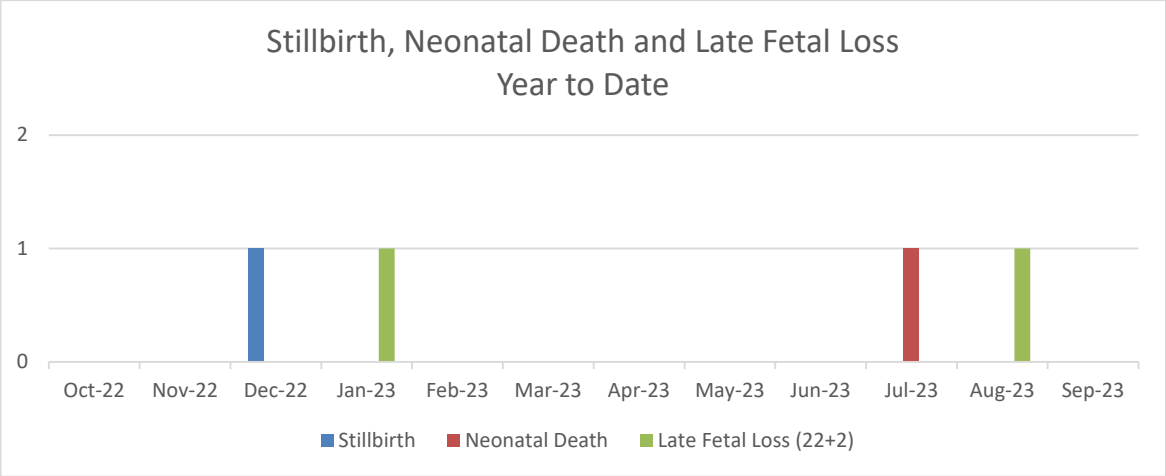
One of the aims of SBLCB v1 – v3 is to reduce the number of stillbirths.
The Trust Perinatal Mortality report for 2021 births was presented in September 2023 at the multidisciplinary perinatal meeting. This report is produced for all Maternity service by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. The stabilised & adjusted mortality rates for our Trust were similar to, or lower than, across similar Trusts.

The report recommends that if the aspiration of our Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths. We continue to undertake the review of every death using the national tool. This review includes the parents' feedback off their care through their pregnancy including the support they receive following the birth.

We are extremely fortunate to have a Bereavement midwife whose care and support is always a major area of positive feedback. We received funding from NHSE to strengthen our bereavement provision and are now recruiting a band 6 bereavement midwife on a fixed term contract to support this role. The Post holder will work alongside the Bereavement Lead Midwife and act as a champion for bereaved parents, providing emotional and psychological support upon diagnosis of a fetal loss or decision to terminate pregnancy due to fetal anomaly. The post will involve audit of the bereavement service, development of patient information in relation to bereavement and pregnancy after loss and teaching peers' bereavement care. They will also provide care to those pregnant following a previous loss.

We understand the national stillbirth position for 2022 will be published in December 2023 at which point we will compare our rates with other units of a similar size.

The chart below shows the rolling data for Still birth, Neonatal Death and Late Fetal Loss for Torbay Maternity Unit for the last 12 months.



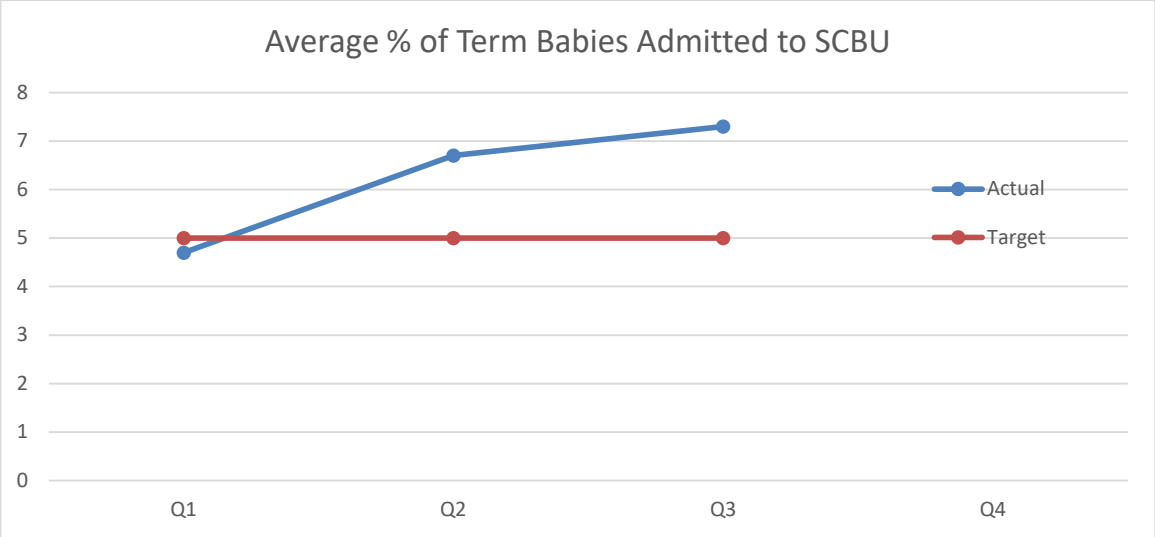
In Q2 we had 2 perinatal deaths. One was a neonatal death; this baby was born alive following a medical termination of pregnancy due to a chromosomal condition . The baby was born showing signs of life and died at 20 minutes of age. This is uncommon but is difficult to predict or prevent.
The second death was that of a late fetal loss at 22+2 weeks gestation . This mother was found to have had a fetal demise when seeking a later gestation termination of pregnancy. The late fetal loss will be reviewed as part of the PMRT process due to the gestational age.

2.5.4 Avoiding Term Admissions into Neonatal Units

The ATAIN collaborative work between the Maternity Service and Child Health is ongoing and is a fundamental part of MIS Safety Action 3. An audit is required of all term babies transferred to the Special Care Baby unit, regardless of the length of stay. The findings of this audit inform an action plan to identify and implement relevant learning. Progress against the action plan is shared with the Board Level Safety Champion as well as with the LMNS.

For Quarter 3 an average of 7.3% of term babies (babies with a gestation at birth of equal to or greater than 37 weeks) were admitted to the Special Care Baby Unit (SCBU). This is an increase from previous reporting periods and remains above our 5% target. Ongoing audit by the team has identified no themes around the increase in admissions this quarter.

The actions taken to address term admissions to SCBU including the relaunch of the ‘Warm Care Bundle’, has resulted in a reduction in the number of babies admitted with hypothermia. All actions to reduce this rate are captured as part of the collaborative ATAIN action plan monitored via both SCBU and maternity governance groups.



There are concerns that the data collection via Badger Net is recording all babies admitted to the Special Care Baby Unit (SCBU) at term regardless of the level of care required. Further confirmatory analysis is ongoing to address this.
It has also been identified through audit that a high proportion of term babies admitted to SCBU meet transitional care requirements rather than neonatal unit care. Work has progressed at pace in the last 4-6 weeks in conjunction with the regional neonatal network to address the transitional care pathway. Plans are moving ahead to allocate a bay as a shared space between SCBU and Maternity for a new neonatal transitional care (NTC) ward in line with the gold standard set by British Association of Perinatal Medicine (BAPM) for care. A standard operating plan has been drafted and is to be shared with the regional team with a planned implementation date of 6th November 2023. Correct coding along with initiation of NTC is likely to reduce the number of babies requiring admission at term as well as reducing separation from their mothers/ care givers.

Following the criminal proceedings related to the Lucy Letby case, several listening events were held with executive representatives and child health staff. Mortality and morbidity data does not indicate any concerning themes or patterns.

2.6 Maternity Safety Champions

The Non-Executive Director for Maternity and Chief Nurse, in their roles as Board Level Maternity Safety Champions, continue to support the maternity service through their monthly walkarounds within the maternity unit. The Non-Executive Director and Chief Nurse undertake walkarounds independently to aid open and honest communication directly between them and members of the maternity team.

The role of the Midwifery Maternity Safety Champion will be transferred to the new Inpatient Maternity Matron within Quarter 3.

Updates on concerns that have been raised by staff include:

- **'Brigid' electronic maternity observation module** - very positive feedback was provided by staff regarding the new system in which maternal and neonatal

observations are recorded directly onto an electronic module which interfaces with the new maternity Electronic Patient Record (SystmOne). Abnormal observations are then escalated automatically to senior members of midwifery and medical staff, aiding early recognition of deterioration and more timely review and treatment. However, staff did express their frustration at the length of time the process of approval had taken.

- **O&G Consultant cover** – has been raised by maternity staff, with particular emphasis on shortages within the Consultant body and the challenges of providing responsive and effective consultant cover. The impact that this has on the O&G Registrars was also raised.
  Action: This issue has been raised by the Clinical Director for O&G, who is also one of the maternity safety champions and an options appraisal briefing paper has been drafted and discussed with senior medical staff and executives within the trust regarding additional O&G Consultant staffing. A full-service review around capacity and workforce within the speciality is in progress with an aim to conclude by the end of October 2023.

- **Car parking spaces** – the significant reduction in car parking spaces for on call community midwives has been raised to the safety champions and the need for 6 dedicated spaces to facilitate direct access at close proximity for these staff members.
  Action: Ongoing discussions are being held between senior midwifery staff, the operation manager, and the car parking department.

2.7 Perinatal Quadrumvirate – Culture and Leadership

This is a national programme of work to address Perinatal Culture and Leadership in all organisations in England. 4 members of the Perinatal team attended the first part of this programme in July 2023 in Birmingham. The team is made up of the Director of Midwifery, Obstetric Consultant, Operational Manager and Neonatal Matron. Ongoing work over the next 6 months will include action learning sets as well as participation in the SCORE culture survey which is due to start imminently. The maternity team have been asked to attend the Torbay and South Devon Board of Governors meeting in December 2023 to highlight ongoing work. It is planned to present as a Quadrumvirate at this meeting.

3.0 Workforce

3.1 Sickness

The maternity service has seen a slight rise in sickness rates due to Covid, especially throughout September. This has affected both maternity and medical staff.

3.2 Preceptorship

5.2 FTE preceptee midwives are in the process of commencing their 12-month fixed term preceptorship posts. We have advertised for expressions of interest from this staff group for 3 of these preceptee to be based in community midwifery teams. The successful candidates will be allied with a named midwifery team, but will work for the first 6 months of their posting within the hospital-based team, in order to provide additional support.

Following this they will move out to work in their nominated midwifery team for the latter 6 months. This is part of our ongoing efforts to fully establish each community midwifery team to 8.0 FTE.

3.3 Education

To address the increasing educational requirements associated with the Maternity Incentive Scheme as well as those outlined in the Single Delivery Plan, we have had to strengthen the capacity of the team to deliver all training needs. The vacant Maternity Support Worker & Training Facilitator post has been filled by an external candidate who has relocated with vast vocational training experience. We have also enabled a fulltime band 6 midwife from within the current establishment to provide additional education and training support for all staff. The role also involves supporting preceptee midwives both in the hospital and community setting.

The service-wide organisational change consultation to align shift times across the community and hospital teams has now concluded and the new shift system will commence in November 2023.

3.4 Health Education England (HEE) Feedback

The Board will recall an update following a visit by HEE in Autumn 2022. This was in response to some feedback around the training experience of Post Graduate doctors in training. A range of actions were agreed and have now been completed by the service. A review meeting took place with HEE in September 2023 and the service will continue to work to address any further recommendations once the feedback is received. The ongoing mechanisms to strengthen the training experience is also being captured within the ongoing service review around the capacity of the current workforce.

4.0 Maternity Incentive Scheme (MIS) (Year 5)

4.1 Torbay and South Devon NHS Foundation Trust was successful in achieving 10 out of 10 safety actions for the year 4 of the MIS. The full rebate was issued to the Trust in June 2023, and we have also just received confirmation of an additional rebate as a proportion from other Trusts that were unsuccessful. The team is working in collaboration with the financial and operational care group team to ensure adequate reinvestment of funds back into the service to address any areas for development in year 5. This will include purchasing of digital blood pressure machines for all community midwives, further investment into adequate centralised fetal monitoring as well as some backfill of staff to meet the training requirements of the core competency framework for all maternity staff.

4.2 Year 5 scheme was launched at the end of May 2023. Evidence of compliance via self-declaration by Trusts is to be submitted by the 1st of February 2024. Additional requirements have been added to the scheme this year which may impact on the ability to achieve compliance in all the ten safety actions. Due to the impact of ongoing industrial action across England, there has also been a national request for the training trajectories to be reviewed to reflect challenges in attendance in training. Confirmation of this request is awaited however we have not seen a significant impact in compliance locally.

The service has reviewed the requirements for each of the safety actions. A high-level summary of any areas of risk and mitigation is provided below.

4.2.1 – **Areas of Risk**

Safety Action 3- Transitional Care services
Action - Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

Mitigation
Child Health is working in conjunction with the maternity team and the Neonatal Network to review pathways of care; this includes consideration of a Neonatal Outreach service. As described in section 2.5.4 this model of care is progressing with an action plan in place.

Safety Action 4 – Clinical workforce planning

Obstetric Workforce
Action - Trusts should implement RCOG guidance on compensatory rest for consultants working on call out of hours. Assurance of evidence is required or an action plan to address any shortfalls in compliance should be shared with Trust Board and LMNS.
Mitigation – Audit being conducted on number of occasions that Consultants are utilised out of hours. Ongoing service review (as per section 3.0) to reflect the potential shortfall and impact. Development of a SOP in progress.

Neonatal Workforce

Action - The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical and nursing staffing.
Mitigation – This standard was met previously. Assurance required that this has not altered and if it is likely that this standard is not going to be met, an action plan is required to address deficiencies. There is an action plan in place within the child health speciality to review workforce and the Director of Midwifery is collaborating with the speciality to ensure progress. This is also discussed as part of the Quadrumvirate leadership team.

Safety Action 6- Saving Babies Lives – see 2.5.2 for more detail.

Action - Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

Mitigation - To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The maternity service is confident that it will meet this target for compliance. The implementation tool is being utilised by the team and early indications demonstrate achievement as required. However, the LMNS must

set local standards and trajectories rather than this be dictated nationally. A meeting to agree these is yet to be set up. This tool will then provide a definitive response to all the required elements.

Safety Action 8- In house Training

Action – A local plan is in place for implementation of Version 2 of the Core Competency Framework (V2 – released June 2023) This increases the requirement for perinatal training especially in relation to fetal monitoring training. Consideration will need to be given to additional training requirements for midwives and obstetricians to ensure compliance rates of 90% It is estimated that an additional 7.5 hours of training time will need to be allocated.

Mitigation – The service already includes a significant proportion of the training that is outlined in the Core Competency framework. An additional 7.5 hours of training is required for midwives and doctors to complete fetal monitoring training. This is likely to be in addition to the calculated training uplift within the service and is likely to add some pressure to rostering of shifts. Agreement has been made to allocate some of the MIS rebate to enable backfill of such shifts.

Safety Action 9 – Board assurance on safety and quality

Action- Alongside the Board review of maternity and neonatal quality, the Trust's claims scorecard must be reviewed.

Mitigation – A quarterly meeting has been held with Litigation team and maternity Governance team to review triangulation of complaints, claims and incidents. An update from this meeting will be shared within the quality reporting framework within the organisation. The Board level safety champions are invited to attend.

4.3 The MIS enables the Trust to demonstrate continual improvement in the safety actions detailed. This may require further resources or investment to address and enable full compliance. The service would escalate any requirements via the governance route of the Family and Communities care group structure.

5.0 Exploring the attrition and retention of midwifery professionals.

Earlier this year research midwives from Kings College London were commissioned by Devon ICB to undertake a case study into the reasons midwives are leaving the profession and how best to retain staff. This study was undertaken in Torbay and South Devon due to the positive work of the retention midwives. The report was shared with the ICB and maternity service in late summer and the team have recently met with the ICB to discuss next steps.

Overall, the impact of the work of the retention midwives was positively acknowledged. The key influencing factors in the desire to leave the profession were:

- the perceived changes in the role of the midwife
- an erosion of professional autonomy
- workplace culture and relationships.

These issues are not unique to Torbay and resonate with conversations and concerns on a national and international level. The report indicates that:

"*Torbay and South Devon NHS Foundation Trust Maternity service in a position to lead the way in starting to explore potential answers to these thorny problems. It is a Trust that has already shown a wish to examine and grapple the workforce issue and with transformational leadership, solutions may be found.*

The ICB wish to use the findings and recommendations from the report to tackle the retention issue across the Devon system. They will formulate a plan to share the learning at system and regional level and formulate a Devon wide action plan that providers can adopt. Clarification will also be gained from the authors around wider publication and anonymisation.

Conclusion

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. They continually review and can evidence progress against a number of trajectories in order to improve the quality of care delivered. The perinatal team will embed the strategic aims of the Devon LMNS to ensure that care is personalised and responsive to the needs of women, families, and staff.

Recommendations

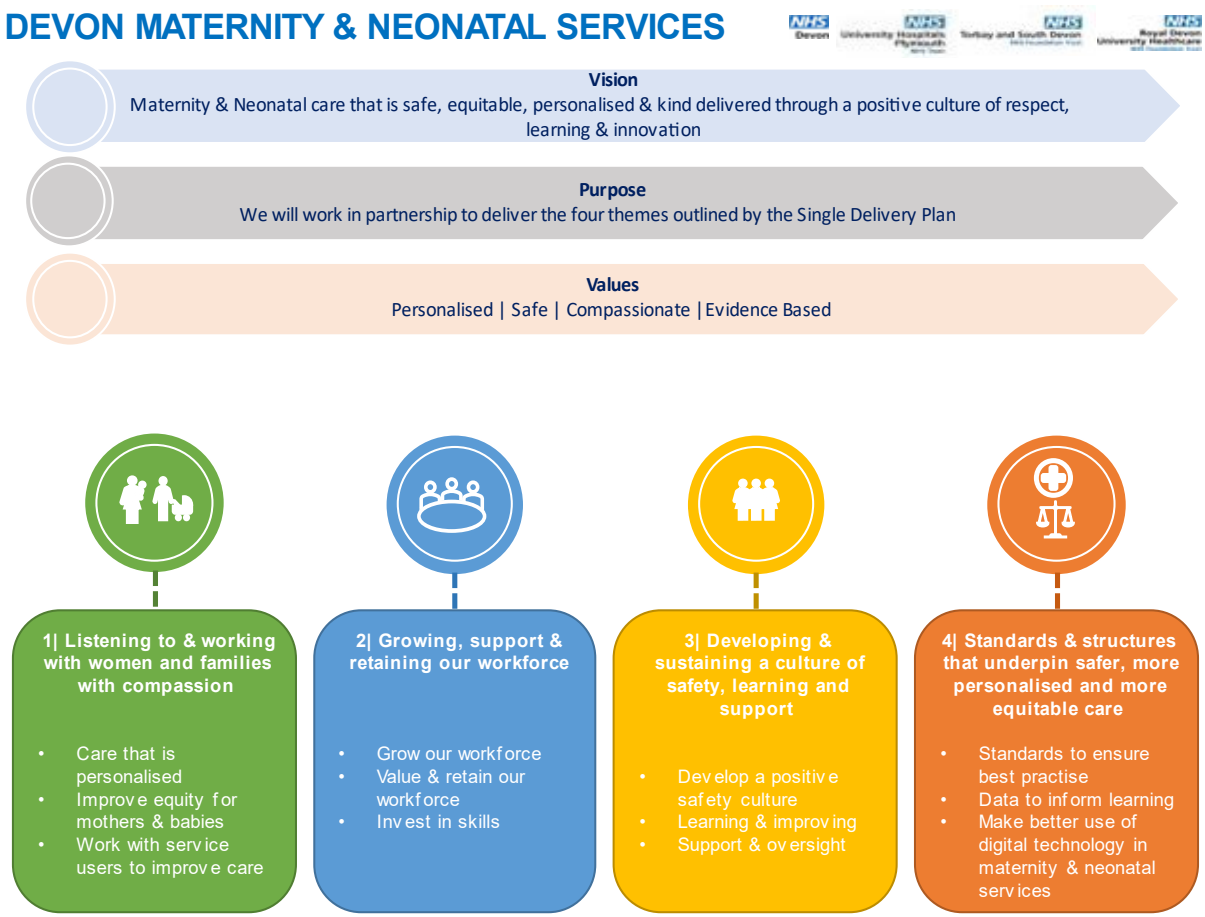
- Note the progress and compliance position with regard to the priority areas
- Note the key quality and safety issues identified in the report.
- Note the potential areas of risk and mitigation to full compliance with Maternity Incentive Scheme year 5.
- Note the plan to present an overview of maternity services to the Board of Governors in December 2023.
- Note the intention to utilise the findings of the case study into retention at system and regional level.

Appendix 1

Torbay and South Devon NHS
NHS Foundation Trust

Strategic and Operational Plan Summary (2023-25)

Business plan for	Maternity and Obstetrics
Service lead(s)	Joanna Bassett – Director of Midwifery
	Gwen Hotine – Operational Manager



Version no.	Date	Author/ Lead	Job title	Details of Change	Archiving location(s)

1	September 2021	Rachel Glasson	Head Of Midwifery	New	DirMan/Strategy/5 Year Plan/21 23
1.1	April 2023	Joanna Bassett/ Gwen Hotine	Director Of Midwifery/Operational Manager	Updating	DirMan/Strategy/5 Year Plan/23 25

Contents

PRIORITIES 2023/25 NHS

NHS England (NHSE) released its 2023/24 priorities and operational planning guidance, outlining three priority areas for the service: to recover core productivity; to progress the aspirations in the Long-Term Plan; and to transform the health and care system for the future.

The NHS Long Term-Plan, published in 2019, sets out the ambition to ensure that the NHS is fit for the future and that everyone gets the best start in life.

The Ockenden Review published 2 reports in 2020 and 2022, followed in October 2022 by 'Reading the Signals': report into East Kent Maternity services.

In March 2023, NHSE published the three-year delivery plan for maternity and neonatal services. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families (NHSE 2023). The plan incorporates 4 key pillars/themes:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care

The Single Delivery Plan aims to summarise the ambitions and priorities of the last 8 years of the Maternity Transformation Programme in a single guiding document.

At Torbay and South Devon NHS Foundation Trust, our aim is to align our team to a common purpose so that we deliver excellence for our families.

SERVICE OVERVIEW

Services provided.

Obstetrics and maternity

The obstetric and maternity service provides care for women and their families, from the point the pregnant person presents to the maternity service at the beginning of their pregnancy through to 28 days following the birth of their baby. The service is provided as both a community and hospital-based service.

Torbay and South Devon NHS Foundation Trust cares for approximately 2350 women per year with approximately 2000 births per year and provides an integrated model of midwifery for all women. Pregnant people are risk-assessed at booking (before 12 completed weeks of pregnancy) in respect of the tariff payment pathway they will follow

i.e., standard, intermediate (can be for either clinical or complex social reasons), intensive.

We can offer our service users the choice of a birth in our acute unit on Delivery Suite, at the Freestanding Midwifery Unit (White Lake), based within Newton Abbot Hospital, as well as offering home births. We also offer specialist obstetric input to women who need it (Fetal medicine, Maternal medicine, Preterm Birth, Pelvic Health, Diabetes, Bereavement and Public Health Specialist Midwifery input).

Key outcomes/performance indicators (22/23)

Birth rate- 1847

Booking data – 2336

Birth to midwife ratio – 1.19

Stillbirth/neonatal death data – 5 stillbirths =0.3%

Homebirths/MW-Led birth in White Lake – Homebirth/BBA = 3.3% White Lake = 0.4%

Maternity KPI

NHSE trajectories that include:

- Safety
- Continuity of Carer
- Personalisation and Choice
- Prevention
- Postnatal
- Digital
- Perinatal Mental health

Antenatal and newborn screening standards (PHE)

Saving Babies Lives Version 3 (June 23)

Maternity Incentive Scheme NHSR

Three-year delivery plan for maternity and neonatal services 2023 - NHSE

Core Competency Framework Version 2 (June 2023)

UNICEF BFI Level 3 standards

Relevant partnerships/network arrangements

Maternity

Local Maternity Systems were formed in 2016 to act as transformational bodies and support system implementation of recommendations. In 2023, the environment looks very different, with neonates now comprising a core part of our work. They have transitioned to Local Maternity & Neonatal Systems and have a responsibility to monitor and assure safety & quality, and have transitioned to a position of statutory authority as the maternity arm of the ICB. The responsibility of ICBs to monitor and improve maternity services is significant and requires dedicated resource and specialist knowledge & expertise. It is important to note that the SDP does not replace all the guidance that came before it. There are 2 other providers within the Devon system:

University Hospitals Plymouth and Royal Devon University Hospitals (Eastern and Northern)

The team continue to work with the Maternity Neonatal Voices Partnership (MNVP) to ensure services are developed in conjunction with service users.

The maternity team also work closely with the Southwest Regional Maternity and Perinatal Team, actively participating in the network meetings held to share learning and support on-going development and innovation. This includes links with the Academic Health Science Network (AHSN) to develop Southwest initiatives, such as smoking cessation in pregnancy, PeriPREM and to share learning from quality improvement initiatives or unexpected outcomes. This involves links with the national Patient Safety team.
Health Education England provide guidance and support around education, training, and workforce. The team also work closely with the University of Plymouth as well as other Academic Institutes of HE.

Recent achievements -

Maternity

- Implementing the requirements of Maternity Incentive Scheme (MIS) NHS Resolutions 10 safety actions for maternity services, resulting in a rebate of a proportion of the CNST premium. (Year 4).
- Continuing to provide flu pertussis and Covid vaccinations as part of their routine care pathway.
- In the 2022 CQC maternity survey, we performed better than other Trusts, with 43 answers aligning with other Trust responses. We did not have any questions in which we performed worse than others.
- Active participation in the Devon LMNS, ensuring partnership working with neighbouring providers and the Integrated Care System (ICS).
- Significant reduction in smoking rate at time of birth
- Implementation of a smoke-free pathway with specialist band 4 maternity support workers who support women and families. This has resulted in reduction in smoking rates.
- Introduction of twice daily consultant-led ward rounds on Delivery Suite.
- Self-administration of analgesia as QI project
- Provision of evidence on how service is meeting Ockenden safety recommendations.
- Compliance achieved against Ockenden 2020
- Continuation of Pathways to Excellence and shared governance councils.
- Embedded Maternity IT system project
- Implemented BRIGID electronic observation system within the EPR
- Development of a digital strategy
- National recognition for Bereavement Midwife at Mariposa awards
- National service review by Kings College into retention of midwives

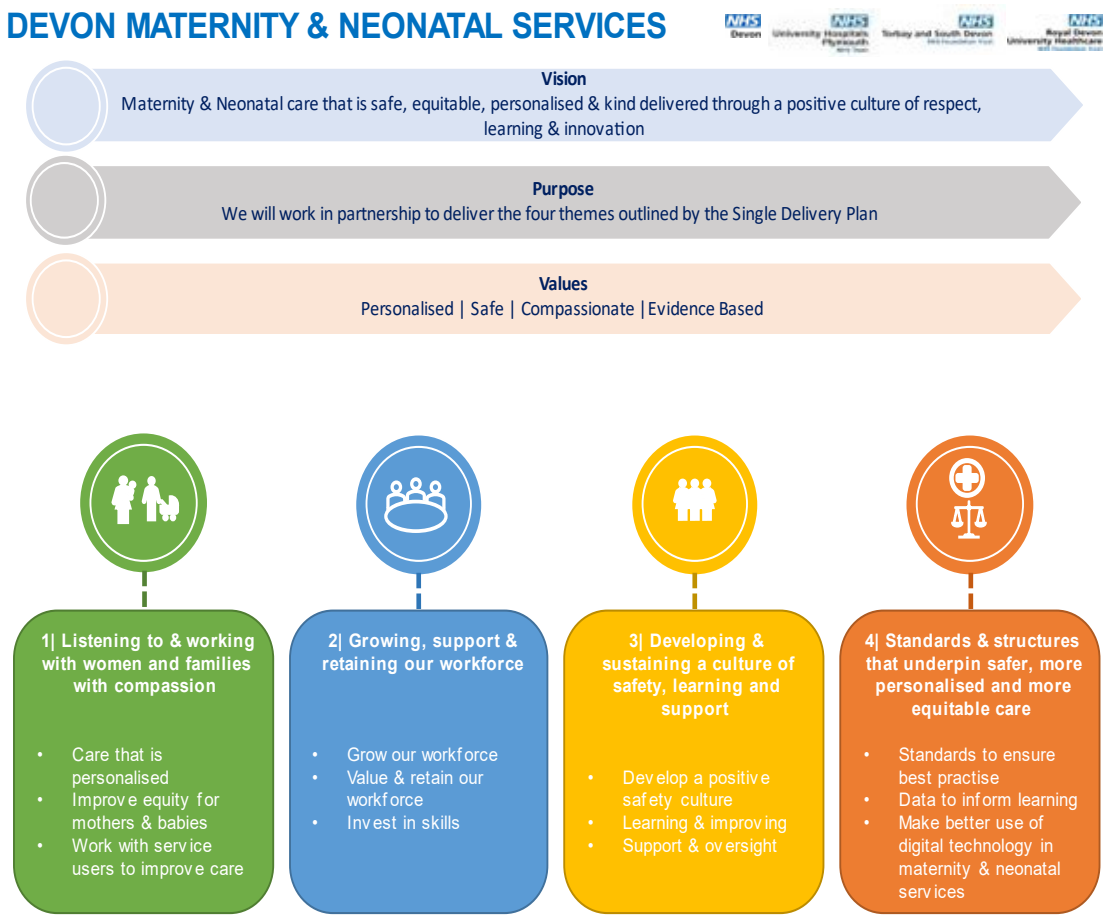
- Recognition and acclaim for work completed into retention of staff by retention midwives.
- Legacy Midwife role introduced.
- New preceptorship model “Acorn to oak” launched.
- Reaccreditation by UNICEF for level 3 BFI
- National funding received for support for early career midwives, bereavement MW and Obstetric Governance support, as well as for pelvic health and preterm birth.
- HOPE box scheme launched to support women who are unable to parent their children.
- Launch of Birth Afterthoughts Clinic – debrief service.
- SW Perinatal Awards – Winners and Runners-up in three categories: Leadership, Rising Star, and Innovation
- Hosted International PMA conference.
- CMIDO award for MSW for Smoke cessation work

SERVICE STRATEGY

Strategic context

Maternity

Devon LMNS has developed a maternity strategy that aligns to the three-year Delivery Plan. This was devised in conjunction with the Directors/Heads of Midwifery, the Senior LMNS team as well as by representatives of the MVNP.



Trust Strategic Objectives

The strategic aims of Torbay and South Devon NHS Foundation Trust are reflected in the operational planning of both Maternity and Gynaecology.

- Trust Strategy
- Our Quality and Safety Plan 2021-24
- Our People's Promise & Plan 2021-24


Our strategy
Our vision
Better health and care for all
Our purpose
To support the people of Torbay and South Devon to live well
Our goals
Excellent population health and wellbeing
Excellent experience in giving and receiving care
Excellent value and sustainability
Our priorities
What matters to you matters
Building healthy communities
Thriving people
Improving quality
Creating partnerships
Improving sustainability


Zero Avoidable Deaths
Deliver What Matters Most To Our People
Quality Goals
Continuously Seek Out And Reduce Harm
Excellence In Clinical Outcomes

Key strategic priorities / developments for next 1-3 years

1. **Listening to and working with women and families with compassion**

Successes

- Personalised care plans in place with ongoing work as part of LMNS to strengthen these templates and audit processes.
- Audit on personalised care was completed in February 2023
- Midwifery continuity of care in place in 6 integrated teams
- Baby Friendly standards in place – Level 3 reaccreditation process November 2022
- Working with LMNS to address equity and equality plans. Also completed Trust SWOT analysis with Trust Lead for Diversity and Inclusion in March 2023 for the NHSE equality delivery system toolkit. Collaboration with service users for this submission.
- Excellent progress on reducing tobacco dependency but need to recognise how deprivation and ethnic diversity impact on outcomes in the most deprived deciles. SATOD reduction significant.
- Introduced implicit bias training for all staff.
- 15-step action plan completed with MNVP 2021 and 2022
- Self-administration medication on ward following feedback “you said we did “
- Birth After Thoughts Service introduced October 2022
- Award-winning Bereavement Midwife 2023
- Capital investment to provide updated mortuary facilities within maternity footprint.

Priorities

- Introduce enhanced continuity of care maternity support worker roles within Torbay teams.
- Implement digital personalised care plan/decision-making tool within EPR.
- Strengthening feedback from women and families, including more collaboration with neonatal services.
- Embedding stronger feedback mechanisms for feedback and engagement – CAFÉ template.
- Amplifying the voices of those from vulnerable and diverse backgrounds
- Devon ICS co-production of complaints
- Explore use of software – Torbay Charts for engagement and informed consent – Induction of labour
- Fully embed the Pelvic Health pathway
- Recruit band 6 Bereavement Midwife to enhance the service.

Growing, retaining, and supporting our workforce

Successes

- Overall improvement in the culture within maternity, following initiatives and changes by Retention Midwives with action plan in place.

- Benefits identified through Retention MWs being PMAs, as provided capacity to embed A-Equip model to support wellbeing and QI.
- Ongoing service review of causes of attrition and retention
- Working alongside retention leads locally and regionally.
- New EPR systems and admin staff in place to reduce administrative tasks for MWs.
- TNA in place

- Early career training, RAW and Fear & The Art of Midwifery Training.
- Embedding A-Equip Model & hosting a national PMA and Retention of Midwives Conference.
- Additional administration support in place, Operation Manager and Roster Administrator.
- Midwifery establishment funded to birth rate recommended level.
- Leadership programme for band 6 and 7 midwives commenced in early 2023.
- Acorn to oak preceptorship programme and legacy midwife role in place
- Training needs framework encompasses core competency requirements.

Priorities

- Shift consultation to make working patterns more attractive to staff and retain current staff.
- Devon-wide review of complaints process to enable links with MNVP.
- Continuing development and support of early career MWs.
- Improving culture and wellbeing within maternity and multi-disciplinary team.
- Consider further birth rate + establishment review.
- Wellbeing focus - away days/coaches/reflexology/psychological support/GREATix/Themed RCS/RCS for Dr's/early careers specific and bespoke training.
- Retention action plan for next 3 years (triangulate to staff survey findings).
- Launching a department-wide culture and civility focus.
- Collaborate training as perinatal service.
- Workforce planning strategy for all perinatal staff to be developed (MSW, MW, Obstetric workforce, Neonatal staff, and Sonographers).
- Continue work on reducing discrimination in workplace.
- Formalise mentorship programme for newly appointed band 7 and 8 midwives.
- Continue to improve support for PGDIT in line with RCOG principles and HEE recommendations.

Developing and sustaining a culture of safety, learning and support

Successes

- Band 7 Leadership Development Programme
- Train the trainer Delivery Suite MOMUS training
- Introduction of BRIGID to support robust escalation of clinical concerns.
- The perinatal quadrumvirate is part of cohort 3 and is beginning the national perinatal culture and leadership 6-month training programme in July 2023.
- Perinatal services are part of the Trust-wide programme to implement PSIRF; bespoke focus workstreams are also planned by ICS and regional team.
- Audit plan in place with mechanism to address and act on feedback (e.g., matron listening forum, Director of Midwifery – Hear to Here Forums).
- DOM completing MSc Healthcare Leadership – dissertation will address leadership in practice and impact on service.
- Dissemination of learning from incidents – LASER, Governance noticeboard, Governance newsletter.

Priorities

- FTSU training/e-learning
- Investigate and develop ways of involving all staff into QI
- Inclusion of MNVP in complaints process
- Fully embed PSIRF within the Trust and maternity in 2023
- Consideration of additional training to comply with Core Competency Framework V2

Standards and structures that underpin safer, more personalised, and more equitable care.

Successes

- BRIGID introduced – compliance with MEWS & NEWTT2
- CNST year 4 compliance
- Good use of PMRT
- Continue national reporting of MBRRACE data
- Continuous audits of certain metrics
- Guidelines updated based on NICE recommendations.
- National maternity self-assessment completed in May 2022 and reviewed in May 2023
- Ongoing work within Trust and with ICS to ensure high quality data submission to national bodies.
- Maternity digital strategy in place
- Maternity engagement with CINO regarding the Trust-wide EPR procurement
- Digital midwife completed foundation course for digital leaders in April 2023
- Internal governance review concluded May 23 – action plan in place.

Priorities

- Implement Saving Babies' Lives V3
- Trust wide EPR procurement
- Improved data analytical work
- Increase capacity of digital team
- Compliance with CNST year 5 regarding MSDS submissions.
- Consider improvements to SystmOne, for example Partogram.
- Antenatal steroids – implementation of a regional guideline

Maternity

Operational delivery:

- Ensure the estate meets the needs of the maternity service to deliver care to women and their families in the most appropriate location.
- Support staff to think innovatively in the provision of care given the ever evolving and increasing requirements for maternity care.
- Achieving compliance in the Maternity Incentive Scheme
- Increase CQC rating from Requires Improvement
- Work to deliver care that is aligned to three-year delivery plan

Activity and performance (KPIs):

- Continue to meet public health targets
- Targets for antenatal and new-born Screening
- Devon LMNS/Maternity arm of ICS transformation plan/trajectories
- Long-term plan and three-year single delivery plan
- Meet emerging national report findings and actions, e.g., Ockenden.

Financial challenge:

- To continue to provide high-quality services within financial envelope that meet all the national requirements.
- To work with national, regional and local teams to ensure that any funding opportunities are fully utilised.
- Support the Trust in its recovery plan for exit from the SOF4 framework

Clinical workforce and support:

- Articulate position and risks/mitigation regarding obstetric workforce and challenges for optimum staffing and support of junior doctor workforce
- Workforce strategy to be devised to articulate plan to address workforce gaps and opportunities.
- Explore the escalation and midwifery senior support required out of hours in conjunction with regional and national stance.
- Requirement to increase training time needed to align with Core Competency Framework V2

Estates and facilities:

- Continue to explore the redevelopment of McCallum Ward into an Alongside Midwifery Led Unit in line with STP and CCG/ICS plans.

Enabling further development of transitional care facilities and improved parent facilities for SCBU and John MacPherson Ward

- In the absence of Alongside Midwifery Unit, offer women a choice of White Lake and homebirth, as well as Consultant Unit, depending on risk categorisation.
- Initiate telephone triage phone line in non-clinical area 7 days a week
- Work in collaboration with surgical/theatre teams to staff a second emergency obstetric theatre out of hours.

Other local providers:

- Work collaboratively with neighbouring maternity providers to ensure safe and sustainable maternity services across Devon.
- Work with other stakeholders to ensure good communication and safe transitions of care, e.g., SWAST/PHN teams.

STP and commissioner challenges:

- Implementing the Devon ICS Single Delivery Plan and meeting the relevant trajectories

Risks to delivery of plans

- Lack of investment in estates and resources (staffing, equipment)
- System-wide reconfiguration of services
- Trust-wide operational challenges impacting on space and footprint within maternity.

Workforce

Current position- start of 23/24

Vacancies – 9.87WTE

Sickness Absence

Jan 23 = 8.67%

Feb 23 = 5.75%

Mar 23 = 3.65%

Apr 23 = 3.29%

Turnover - 10.98%

Bank and agency usage - No agency Bank – 5.14% Additional/OT – 5.74%

Age profile >55 - 20.29%

Staff satisfaction - pulse survey ISU average 52.74%

Staff survey 2022- largest increase in We Work Flexibly

Areas of lower performance relate to burnout, work pressures

Anticipated risks –

- inability to secure funds to complete recommended consultant workforce uplift
- potential challenges in recruiting to posts
- age profile of midwives resulting in loss of senior, experienced midwives. Resulting recruitment is early career midwives

Development plans

Future Workforce planning

Development of full 3–5 year workforce strategy in conjunction with ICS and HR/People Lead. To align with NHS 15-year workforce strategy (released June 23).

This will include the ACP role in Midwifery.

Apprenticeship roles – MSW role commencing 2023.

Sonography training posts.

Obstetric workforce.

Increase focus on research fellows/ practitioners.

Consideration of Consultant Midwife.

FINANCE

Developments

Alongside Midwifery Led Unit and Transitional Care/SCBU Facilities.

Additional funding to meet identified workforce gaps, including specialist posts that are currently funded externally, with an expectation that these will be funded substantively by the Trust.

Meeting CIP target for the speciality. Identifying recurrent schemes.

Additional training time to meet requirements of Core Competency Framework.

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Dependencies, risks, and issues

Internal/corporate dependencies

Building a Brighter Future.

Ability to release funding to enable infrastructure improvements and meet staffing requirements.

SOF4 – exit strategy.

Organisational restructure/provider collaborative.

Trust-wide EPR.

External dependencies

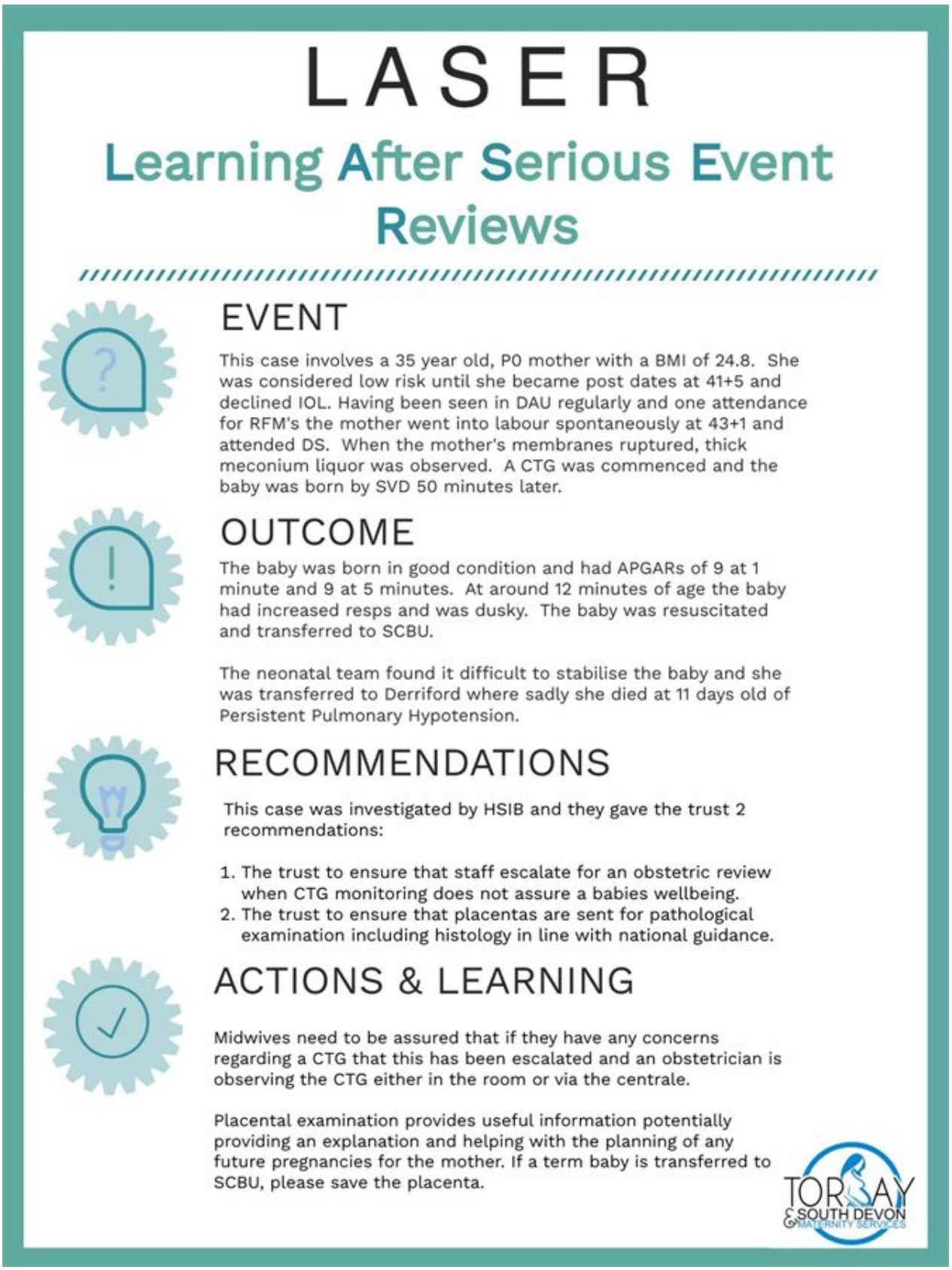
There is a national spotlight on maternity services and clear expectations of the safety and quality metrics to be achieved.

NHSE/HEE.

Risks and issues

Lack of investment within maternity services will place the organisation at risk as the team will not be able to meet the requirements set by NHSE, NHSR and HEE.

Appendix Two



NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors	
Report title: Culture Update	Meeting date: 25th October 2023
Report appendix:	1. People Promise Progress 2. The Board of Torbay and South Devon NHS Foundation Trust Commitment to Create and Inclusive Culture v 2
Report sponsor:	Chief People Officer
Report author:	Chief People Officer and Associate Director of People
Report provenance:	Appendix 1: People Committee Oct 23 Appendix 2: Board Development Day 18 Sep 23
Description/Purpose of the report and key issues for consideration/decision:	In recognition of the importance that the Trust places on organisational culture, this agenda item is quarterly, and is in place so that the Chief People Officer has opportunity to update the Board on progress, themes and trends that are or will impact on our people priority to create an environment at work where everyone feels safe, healthy and supported. Key Updates: 1. The Leadership Framework, approved by Board in May 23, has now been launched. 2. The Management Inductions, the first stages of the management development plan, have begun. 3. The Embedding an Inclusive Culture plan, approved at Board in July 23, has been incorporated into the People Promise programme of work and progress commenced (Appendix 1). 4. In recognition of the Corporate risks surrounding EDI and the People Hub, and the workforce resource currently available to treat the risks, the Executives have supported an uplift in team resource utilising other vacancies within the Trust: this does not grow the workforce or increase workforce costs. These posts, once approved through vacancy control, will be live for recruitment in Nov 23: this is testament to the commitment to focus resource in embedding an inclusive culture. 5. The Board held a culture development day on 18th Sep 23 at which a draft Board Commitment to Create and Inclusive Culture was shared. Comments were received and have been incorporated into v2 for Board approval. It should be noted that the commitment is aligned to the NHS Sexual Safety Charter, which the Trust intends to sign up to. The Board is invited to sign up to the wording of the Commitment (Appendix 2) – when agreed, work will commence with the communications team of how to best visually present and communicate the commitment. 6. Board draft EDI objectives will be presented at the next Board development day. Key points: 1) Noting of progress to embed a culture of inclusivity 2) Approval of draft Board commitment

Action required:	**For information ☐**	**To receive and note ☐**	**To approve ☒**
Recommendation:	To approve Board commitment		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The priorities and deliverables of Our People Promise is the People enabling strategy for the organisational strategy; the aim is to create a culture at work where are people feel safe, healthy and supported, which is fundamental to furthering our purpose.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 2 - People Objective 11 – Equality, Diversity and Inclusion		
Risk: Risk ID: *As appropriate*	Risk 3536 (Risk on People Hub due to increased demand) Risk 1697 (Difficulty in recruiting service critical staff and scheduling of staff) Risk 3030 (Staff fatigue) Risk 3547 (Upwards trend in EDI related investigations)		
External standards affected by this report and associated risks	Care Quality Commission NHS People Promise and Plan National Oversight Framework		

Torbay and South Devon
NHS Foundation Trust

The Board of Torbay and South Devon NHS Foundation Trust Commitment to Create and Inclusive Culture

Our NHS is built on the values of: everyone counts, dignity and respect, compassion, improving lives, working together for patients, and commitment to quality. These values underpin not only how healthcare is provided to our patients and carers but also how we behave towards our colleagues and our people.

We are one big, diverse team, united by a desire to provide better health and care for all. Our People Priority is to build a healthy culture at work where our people feel safe, healthy and supported. Our People Promise is how we work together to improve the experience of working in the NHS.

The Board pledge to the staff[1] of Torbay and South Devon NHS Foundation Trust:

- We do not tolerate any form of discrimination, harassment, bullying or violence.
- We each have a responsibility and role to play in making the NHS a place where we all feel we belong.
- We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate behaviours.
- We take positive action to reduce and remove inequalities for staff, patients and the public.

What our staff can expect from us:

- We lead our people and manage our processes in line with our compassionate leadership approach: we include with care, we listen with genuine curiosity, we act with courage.
- We listen with respect to the voices and lived experience of colleagues, patients, and all individuals and groups who experience discrimination or lack of fair representation.
- We work together with our people to identify, reduce and remove inequalities within our organisation.
- We use our influence and our voice to assist others within our local communities to address discrimination, inequality and unfairness.
- We acknowledge that past action has failed to bring about the change we need to see and we recognise and are accountable for our own role in creating a fairer and more inclusive environment within the Trust.

What we expect from everyone who works in our Trust:

- We all recognise that people are different and value people for their difference.
- We all treat people fairly, with respect and without bias.
- We all take personal responsibility for our own words, behaviour and actions and understand our role in creating a fairer and more inclusive workplace.
- We all challenge bullying and harassment when we see or hear it, and report concerns.
- We all listen and learn from the experiences of others. We listen with care and with curiosity and are respectful of people's lived experience.

What we will do together:

- Through our actions, words and behaviour, we create a workplace where everyone feels safe and confident to speak up.
- We work together to reduce and remove unfairness and discrimination within our communities, within the NHS and our partner organisations and within society as a whole.

[1] All Staff, including bank staff and contractors, and student placements


Progress on delivery of Our People Promise
October 2023 update

Our Original Promise Driver Diagram describing two priorities and six deliverables:

Torbay and South Devon NHS Foundation Trust

Driver Diagram			
Our Aim	**Primary Drivers**	**Secondary Drivers (Programmes)**	**Projects**
To build a culture at work where our people feel safe, healthy and supported.	1:- Define and deliver our Inclusive Leadership & Management approach	1:- Co-Create leadership framework & descriptors	Define our clear 'leadership for all' approach- what good looks like
			Framework describing leadership behaviours, expectations
		2:- Leadership recruitment and development based on this framework	Clear programme of leadership development
			Clear management development offer
			Recruit for leaders and leadership potential based on framework
		3:- Equipping managers with the essential skills and confidence.	Develop iManage further
			Relevant resources are accessible
			Develop a basic skills package using a blended approach to developing management, skills and confidence
	2:- Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities	4:- Organisational reshape using span of control and engagement outcomes	Development, eg ILM OD programme
			Utilise outputs to identify a future focussed organisational model
		5:- Workforce transformation programme to deliver clear enabling data & people processes	Improve Processes – Recruitment, Payroll, Workforce Information & reporting, Temp staffing
			Rollout e-Rostering to the Trust workforce
			Continuously Improve the experience of using our services using feedback (from our People teams and the people we support)
		6:- Development of robust strategic workforce plans and process, driving career pathways, learning/development	Career pathways work – non clinical, volunteers, students
			Workforce planning – inc recruiting more volunteers to release time to care
			Delivery of retention project recommendations; including retention conversations and flexible working

Torbay and South Devon NHS Foundation Trust

Progress- October Update

Key points of note for the current update include:

- An update on progress of Priority 1: *Define and deliver our inclusive Leadership and management approach*
- An update/evolution of priority 2: *Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities*, including
  - the inclusion of the Scaling HR Services/People Digital ICS vanguard work
  - expansion of the strategic workforce planning element
  - progress in the Workforce Transformation programme- which has been moved to align to the organisational CIP work, and will therefore be reported within that governance framework after this update
  - Update on the organisational reshaping work: the largely structural elements are now complete and the development of the Care Groups will be integrated within priority 1 and BAU.
- Addition of Priority 3: *Creating and embedding a culture of inclusion*
- *Summary of the metrics for evaluation*

Our Updated People Promise Driver Diagram

Torbay and South Devon NHS Foundation Trust

Our Aim	Primary Drivers	Secondary Drivers (Programmes)
To build a culture at work where our people feel safe, healthy and supported.	1:- Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability	Leadership recruitment and development is based on compassionate leadership framework
		Equipping managers with the essential skills and confidence.
	2:- Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities	Scaling People Services and People Digital (ICS Vanguard)
		Development of robust strategic workforce plans and process, including our New Hospital Programme
	3:- Creating and embedding a culture of inclusion	All managers role model leading with compassion, demonstrating inclusive behaviours creating an environment that encourages feedback and where staff feel able to speak up
		To create an environment free of discrimination, where difference and diversity is encouraged and celebrated giving people a sense of belonging and ability to perform at their best
		Creating an environment where our people are able to be healthy and well (physically and mentally) to be themselves and perform at their best
		JUST CULTURE - Introduction of Just and Learning HR polices, systems, processes and practice.
		To embed inclusion throughout the employee lifecycle: onboarding, induction, training, talent management, appraisal (via Leadership Framework Include, Listen, Act)
		To be recognised as an inclusive and equitable employer committed to ensuring our workforce reflects the community it serves and eliminates pay gaps
		To develop staff networks to gain confidence in sharing their lived experience to inform organisational decision -making and improvements and create a sense of belonging.
		To create and utilise a cultural dashboard for TSD to understand areas requiring cultural development to improve workforce lived experience and patient safety

Priority 1: Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability

Torbay and South Devon NHS Foundation Trust

Phase / product	Start	End
Preparation phase	**pre Aug 23**	**Sep-23**
Phase 1: Raise awareness and build capability	**Sep-23**	**Mar-24**
Phase 1 comms and engagement	Sep-23	Mar-24
Introduction to CL day rollout - cohort 1 (B7+ to VSM)	Sep-23	Mar-24
360 developments and first pilots	pre-Aug 23	Nov-23
Exec Development	Sep-23	Jan-24
Care Group Development (org reshaping)	Oct-23	Mar-24
New Managers Induction	Launch Sep-23	Ongoing
First wave of development packages	Launch Sep-23	Ongoing
Phase 2: Embedding	**Mar-24**	**Sep-24**
Phase 2 comms and engagement	Mar-24	Sep-24
Recognition packages launches and embedding	Mar-24	Sep-24
Accountability approach launches and embedding	Mar-24	Sep-24
Introduction to CL day rollout - cohort 2	Mar-24	Sep-24
New recruitment and onboarding approach	Mar-24	Sep-24
Compassionate Leadership 360 - cohort 1 (B7+)	Mar-24	Sep-24
Exec Development continued (quarterley to become BAU)	Mar-24	ongoing
Development packages (ongoing development)	ongoing	ongoing
New leavers process launched	Aug-24	Aug-24
Phase 3: Expansion	**Sep-24**	**ongoing**
Phase 3 comms and engagement	Sep-24	ongoing
Introduction to CL day rollout - everyone	Sep-24	ongoing
Development packages (ongoing development)	ongoing	ongoing
New BAU established	Aug-24	Aug-24

A phased approach to deliver our Compassionate Leadership Way:

- **Phase 1: Raise awareness and build capability** – through targeted comms and development interventions; particularly focused at the middle, senior and VSM management level to role model the CLA
- **Phase 2: Embedding** – reinforcing and expanding reach of phase 1 interventions; introducing new methods of holding people to account and recognition; introducing our new 360 reflective learning approach and changes to our recruitment/leaver processes
- **Phase 3: Expansion** – Continued roll out of interventions; monitoring progress and adapting approach based on feedback

Co-creating each intervention with colleagues from across the Trust, through 8 Task and Finish Groups

Priority 2 regarding the 'organisation reshaping' has now morphed into Priority 1's agenda under Care Group Leadership Development, following completion of the restructure in Summer 2023.

Priority 1: Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability

Torbay and South Devon NHS Foundation Trust

Current phase: **Phase 1: Raise awareness and build capability** (Sep 23 – Mar 24)

Current position:

Phase / product	Start	End	Current progress
Preparation phase	**pre Aug 23**	**Sep-23**	**Complete**
Phase 1: Raise awareness and build capability	**Sep-23**	**Mar-24**	
Phase 1 comms and engagement	Sep-23	Mar-24	Comms plan created and ready for initial launch 30th September
Introduction to CL day rollout - cohort 1 (B7+ to VSM)	Sep-23	Mar-24	Dates booked, locations identified, and facilitators prepped; ready for launch in October
360 developments and first pilots	pre-Aug 23	Nov-23	360 is currently under construction with the provider Think, due for first pilots in October 2023
Trust Board Development	Sep-23	Jan-24	Initial Trust Board Contracting complete in Sep 23. Awaiting start of CMO, CFO and COO to coordinate development sessions
Care Group Development (org reshaping)	Oct-23	Mar-24	Contracted with CNO, COO and CMO CG development programme and key objectives from their view. OD draft plan created with approach and co-designing session with CGDs on 5th Oct 23
New Managers Induction	Launch Sep-23	Ongoing	First cohort launched 27th Sep 23
First wave of development packages	Launch Sep-23	Ongoing	Prepped for launch as a part of comms plan

Priority 2: Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities

No	Activity
	Creating a common understanding & conviction
1	Working with the SPPs develop a working **definition of SWP** incorporating purpose, need and integration with operational and tactical planning
2	Working with the SPP's develop an **outline framework incorporating principles and governance**
3	Meet with Senior leaders to **test our definition and framework** and identify areas of best practice. (Understanding what works well, doesn't work well, what works elsewhere, level of confidence)
	Building framework and process
4	**Research** current WFP methodologies and processes
5	**Creation of TSDFT approach/methodology** to strategic workforce planning (influenced by conversations in the defining activity) . Clear roles and responsibilities and also skillset required
6	**Train the SPPs** (train the trainer)
7	**Pilot** with the business and refine based on evaluation
	Building capability
8	**Creation of training and upskilling materials** - both planning tools and workforce transformation tools
9	**Identify key stakeholders** that need to be upskilled in specific workforce planning methodology
10	**Deliver training/coaching** to relevant stakeholders SPPs, SWP and key stakeholders in specific tools such as HEE star, 6 step and Calderdale framework and also local training e.g. confident with data
11	**Incorporate into I manage/leadership training**
	Data, diagnostics and reporting
12	**Develop Workforce Insight tool (Tableau) including;** workforce profile, inflows, outflows, supply, labour market
13	**Develop enabling planning tools** e.g local supply and demand tool, fragility dataset to enable prioritisation

Strategic workforce planning - Developing and launching the infrastructure so that we have the right future workforce for our people to work in a calm and safe way

An outline project plan has been created to develop the enabling infrastructure centered around four key phases;

- 1. Creating a common understanding and conviction
- 2. Building frameworks and processes
- 3. Building capability
- 4. Developing data insight tools and analytics.

It is envisaged that phase 1 and 2 will be complete by the end of Q3. Phase 3 will commence in Q4 . Phase 4 is essential and is subject to our ability to progress and utilise Tableau and the appointment of a Senior workforce planning data analyst

Priority 2: Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities

New Hospitals Program

- Scoping work is underway to deliver a baseline by the end of quarter 4.
- Mapping of our current workforce will include our current WTE by profession, pay band and establishment including bank and agency. It will also include an analysis of our workforce profile including demographics, workflows and trends and how these have changed over time in order to identify risks and opportunities.

National NHS Long Term Workforce Plan

- Following the publication of the plan in June 2023, an initial event was held with key stakeholders to reflect on the national context and the key commitments made under each of the three elements : Train, Retain and Reform. This was used to reflect on our local context and the alignment between Devon's workforce strategy and the national plan. This culminated in a discussion about the actions/projects the group felt needed to be prioritised and progressed.
- A summary of the presentation and suggested actions/workstreams can be seen in Appendix B. It is our intention to share this draft with the ICS to understand opportunities for collaborative working.

Priority 2: Making people's lives easier and freeing up time to work in a safe and calm way on agreed priorities

Scaling People Services and People Digital (*new deliverable*)

- In May 2023, NHS England launched the strategic overview of the 'Scaling People Services' guidebook with CPOs and CFOs.
- NHS Devon has been selected as the South-West Regional Vanguard of the 'Scaling People Services' guide. This gives NHS Devon the platform and opportunity to innovate and transform, enabling the People profession to be more efficient and responsive.
- Deloitte is supporting this work which has three key objectives ; Improve Employee and Customer Experience; Reimagining and Harmonising our People Processes; Consolidating and Improving our HR Technology Landscape
- Extensive engagement is being completed with Trusts across the system to understand the current landscape and design the future possibilities.
- See Appendix 3 for an overview/comms.

Workforce Transformation Plan: Delivering clear enabling data and people processes (*going forward this deliverable will be reported as part of the Workforce CIP governance processes)*

- There is a 3 phase plan to deliver e-Rostering to the Trust, where the system and policies will enable greater staffing efficiencies, ward safer staffing and a reduction in agency spend. Phase 1 has already been delivered to the clinical areas. The remaining two phases are underway and are scheduled for completion by 12/25. The reduction in agency spend is due to rosters being completed six weeks in advance, therefore giving ward managers more time to fill staffing gaps before going to agency.
- Recruitment policies, recruitment journey and onboarding materials have all been updated following recommendations by Deloitte, along with the temporary staffing frameworks.
- Generic job descriptions are being developed, which is being piloted on agenda for change roles bands 2 and 3. The development of these job descriptions covers healthcare support workers, medical secretary and facilities assistants. These are scheduled to be developed for review in 11/23

Torbay and South Devon NHS Foundation Trust

Priority 3:- Creating and embedding a culture of inclusion

Update on progress:

- Plan to create a Culture of Inclusion signed off at Board July 2023 and being fully integrated into our People Promise with the development of 3rd priority
- Compassionate leadership is an integral part of the plan
- Mandatory EDI inclusion module has been developed and due to launch end of the year – this is an integral part of creating a culture of inclusion
- Staying well for winter programme underway supporting the health of our people through the winter period
- Staff flu and COVID vaccination programme 2023 underway
- Just Culture Survey was undertaken April – June 2023 as part of the PSIRF (Patient Safety Incident Response Framework) diagnostic and will align with the JLC (Just and Learning Culture) actions
- Just and Learning Culture – Staff side have agreed to support the principles within Royal Devon University Hospital's policy which replaces their disciplinary and and a working group is being set up to take this programme of work forward with the Employee Relations team and staff side
- Trust Board development session undertaken September 2023 which updated the board on compassionate leadership approach and 'turned up the volume' on inclusion.
- Actions of the Culture and Inclusion plan are aimed at increasing measures in NSS, WRES, WDES and will be incorporated into the cultural dashboard currently being developed in our WIT team
- Retention action plan for Trust will be delivered using key retention drivers of supportive management, recognition and growth
- Executive support to grow EDI team from 1 x 0.8 WTE: additional 1 x Band 8 and 1 x Band 7
- Executive support to increase Employee Relations team by 2 x Band 7 to address increase in grievances and to address absence management throughout Trust

Torbay and South Devon NHS Foundation Trust

Evaluation: our Metrics

To ensure delivery of the priorities is driven through our Care Groups, a **workforce/cultural dashboard** is being developed to form part of the Care group assurance framework . This is an iterative process but will include the following lead and lag measures:

Lead (Process) measures

- Number of managers completed compassionate leadership training
- Number of staff completed inclusion training
- Number of teams engaged in WFP interventions/planning
- % of team job plans completed

LAG (Outcome) measures

- Staff Survey and quarterly people pulse
- Formal ER cases
- FTSU complaints
- Retention rates including reasons for leaving, destination on leaving, exit interview
- Temporary staffing usage and cost – bank, agency, Long term usage,
- Absenteeism - cost, reason
- Vacancy

NHS
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NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Updated Trust Constitution		Meeting date: 25th October 2023
Report appendix:	Appendix 1 – Updated Constitution (clean copy) Appendix 2 – Updated Constitution (tracked changes) Appendix 3 – Model Election Rules Appendix 4 – CoG Standing Orders (information only) Appendix 5 – Board Standings Orders (information only)	
Report sponsor:	Director of Corporate Governance and Trust Secretary	
Report author:	Corporate Governance Manager	
Report provenance:	Governor Working Group – 3, 5 and 9 October 2023 Council of Governors – 17 October 2023	
Description/Purpose of the report and key issues for consideration/decision:	Following the implementation of the Trust's new organisational structure in 2023 it became necessary to review and update the Constitution to ensure it is aligned with the revised staff groups ahead of the new election cycle (commencing during November 2023). Unfortunately this left a small window to make these amendments. At the same time the opportunity was taken to bring it up to date to reflect the NHS Foundation Trust Model Constitution, new laws and regulation, such as the revised Fit & Proper Persons Regulations (August 2023) as well as the revised NHS Code of Governance for Foundation Trusts (applicable from 1 April 2023) and best practice. The changes are however minimal. Importantly, it should be noted that matters not necessary to be contained within the Constitution have been moved into a standalone document, notably the Board and Governor Standing Orders. No changes to these are recommended at this time. This approach permits further time to review these documents within the flexibility of our own governance structure whilst ensuring the appropriate legalities are covered within the Constitution; this review will commence shortly. The review has been supported by DAC Beechcroft public law team under a fixed fee arrangement to ensure the balance of objective expertise with value for money. Changes to draw the Council of Governor and Board's attention to: • Inclusion of material transaction review • gender neutral drafting (note the Model Election Rules are a standard document and so this will not be amended) • new provisions to deal with the 2022 Act changes, in particular see new paragraphs 4, 5, 6 and 43 • clarity around term limits for appointments for governors and non-executive directors with reference to the Provider Code of Governance as appropriate • clarity regarding the amendment of ancillary documents – see paragraph 46 • updates to significant and material transaction wording	

	• addition of electronic communications wording – see paragraph 48 • revised classes within the Staff Consistency – see Annex 1 • Removal of Plymouth electoral wards from the South Hams constituency and adding them to the Rest of the South West constituency – see Annex 1 • Extending the Rest of the South West Constituency to include Dorset – see Annex 1 • removal of the standing orders for the CoG and Board, these have been provided as separate documents with additional 'order of precedence text' as interim changes		
Action required:	**For information ☐**	**To receive and note ☐**	**To approve ☒**
Recommendation:	The Board of Directors is asked to approve the updated Trust Constitution.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	An up to date Constitution that reflects the requirements of the Health and Social Care Act 2012, Health and Care Act 2022, Foundation Trust Model Constitution and best practice will enable the Trust to best support the people in its footprint.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources The requirements of the Constitution ensure the Trust's decision-making processes support the triple aim.		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion		
Risk: Risk ID: *As appropriate*	N/a		
External standards affected by this report and associated risks	Terms of authorisation, NHS England licence and regulations National policy, guidance		

Torbay and South Devon NHS Foundation Trust

Constitution

[DRAFT FOR COUNCIL OF GOVERNORS]

Approved on [INSERT DATE OF FINAL APPROVAL]

Table of contents

Paragraph heading and number — Page number

1. DEFINITIONS AND INTERPRETATION

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.2 References to legislation include all regulations, statutory guidance or directions. Headings are for ease of reference only and are not to affect interpretation.

1.3 In this Constitution the following definitions apply:

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

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

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

2. NAME

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

3. PRINCIPAL PURPOSE

3.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in paragraph 3.3 above for the purpose of making additional income available in order to better carry on its Principal Purpose.

4. POWERS

4.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act.

4.2 In the exercise of its powers the Trust shall have regard to:

4.2.1 section 63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim";

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

4.2.3 guidance published by NHS England.

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

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

5. JOINT WORKING WITH RELEVANT BODIES

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

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

6. JOINT FINANCIAL OBJECTIVES

6.1 The Trust must:

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

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

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

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

7. MEMBERSHIP AND CONSTITUENCIES

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

7.1.1 a Public Constituency; or

7.1.2 a Staff Constituency.

8. APPLICATION FOR MEMBERSHIP

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

9. PUBLIC CONSTITUENCY

9.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

9.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

9.3 The minimum number of members in each Public Constituency is specified in Annex 1.

10. STAFF CONSTITUENCY

10.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided that they:

10.1.1 are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

10.1.2 have been continuously employed by the Trust under contract of employment for at least 12 months.

10.2 For the purposes of this paragraph 10, Chapter 1 of Part XIV of the Employment Rights Act 1996 (Continuous Employment) shall apply when determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the Trust.

10.3 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

10.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

10.5 The Staff Constituency shall be divided into descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

10.6 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

10.7 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

11. AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

11.1 An individual who is:

11.1.1 eligible to become a member of the Staff Constituency, and

11.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

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

12. RESTRICTION ON MEMBERSHIP

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual must be at least fourteen years old to become a Member.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member are set out in Annex 6.

13. ANNUAL MEMBERS' MEETING

13.1 The Trust shall hold an annual meeting of its members (the **Annual Members' Meeting**). The Annual Members' Meeting shall be open to members of the public.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 7.

14. COUNCIL OF GOVERNORS – COMPOSITION

14.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

15.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules.

15.2 The Model Election Rules as published from time to time form part of this Constitution. The Model Election Rules current at the date of this Constitution are set out at Annex 8.

15.3 A subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46. An updated version of the Constitution may be published by the Secretary incorporating any revised Model Election Rules.

15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

16.1 Elected Governors

16.1.1 An Elected Governor may hold office for a period of up to three years.

16.1.2 An Elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

16.1.3 Subject to paragraph 16.1.4, an Elected Governor shall be eligible for re-election at the end of their term.

16.1.4 An Elected Governor may not serve on the Council of Governors for more than nine years in aggregate. For the avoidance of doubt, this covers all constituencies such that once an Elected Governor has served for nine years in any one constituency or across a mixture of several Constituencies they are no longer eligible to stand for election in any constituency or be appointed to the Council of Governors.

16.2 Appointed Governors

16.2.1 An Appointed Governor may hold office for a term of up to three years.

16.2.2 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

16.2.3 An Appointed Governor shall be eligible for re-appointment at the end of their term.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

17.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or

17.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

17.2 Governors must be at least sixteen years (16) of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor are set out in Annex 4.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

18.1 The general duties of the Council of Governors are to:

18.1.1 hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;

18.1.2 represent the interests of the Members as a whole and the interests of the public; and

18.1.3 feedback information about the Trust, its vision and its performance to Members, the public and stakeholder organisations.

18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1 The Chair, or, in their absence the Vice Chair, shall preside at meetings of the Council of Governors.

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

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

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

20. COUNCIL OF GOVERNORS – STANDING ORDERS

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

21. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

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

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

22. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

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

23. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

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

24. BOARD OF DIRECTORS – COMPOSITION

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

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair

24.2.2 Non-Executive Directors; and

24.2.3 Executive Directors.

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

24.4 The Chief Executive shall be the Accounting Officer.

24.5 One of the Executive Directors shall be the finance director

24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24.8 At least half of the Board of Directors (excluding the Chair) should be Non-executive Directors. In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in their absence, the Vice Chair), shall have a casting vote at meetings of the Board of Directors.

24.9 The post of an Executive Director may be held by two individuals (provided that the provisions of this paragraph 24 are met in respect of required qualifications) on a job share basis. Where such an agreement is in force the two individuals may only exercise one vote between them at any meeting of the Board of Directors. In the case of disagreements, no vote may be cast.

24.10 The Trust may appoint other individuals who may receive a standing invite to attend meetings of the Board of Directors but such individuals shall not be members of the Board of Directors, shall not have a vote and shall not count towards any quorum requirements.

25. BOARD OF DIRECTORS – GENERAL DUTY

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

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

26.1 A person may be appointed as a Non-Executive Director only if

26.1.1 they are a member of a Public Constituency, or

26.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and

26.1.3 they are not disqualified by virtue of paragraph 31 below.

26.2 On first appointment, re-appointment for each further term and throughout their term of office, the Chair and Non-Executive Directors are required to meet the Independence Criteria. In circumstances where, in relation to the Chair or a Non-Executive Director, the Independence Criteria are not met but the Board of Directors considers that the individual in question is independent this will be explained in the Annual Report.

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

27.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the Provider Code of Governance.

27.2 Removal of the Chair or another Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.

27.3 Subject always to the Provider Code of Governance, the maximum tenure for any individual holding the office of Non-Executive Director shall be nine years in aggregate unless exceptional circumstances apply. For the avoidance of doubt, exceptional circumstances shall be determined on a case by case basis.

27.4 In a situation where a Non-Executive Director becomes the Chair, the maximum tenure runs from the time of first appointment to the position of Non-Executive Director.

28. BOARD OF DIRECTORS – APPOINTMENT OF VICE CHAIR

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chair.

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

29. BOARD OF DIRECTORS – APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

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

29.2 The Senior Independent Director will be available to Governors if they have concerns that the Chair is unable to resolve.

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

30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

30.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

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

31. BOARD OF DIRECTORS – DISQUALIFICATION

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

31.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

31.1.2 a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

31.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or

31.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

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

32. BOARD OF DIRECTORS – MEETINGS

32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Minutes of meetings of the Board of Directors held in private shall be provided as required by the Provider Code of Governance unless exceptional circumstances apply which shall be determined on a case by case basis.

33. BOARD OF DIRECTORS – STANDING ORDERS

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

34. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

34.1 The duties that a director of the Trust has by virtue of being a director include in particular:

34.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in paragraph 34.1.1 is not infringed if:

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 the matter has been authorised in accordance with this Constitution.

34.3 The duty referred to in paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In paragraph 34.1.2, "third party" means a person other than:

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

34.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extend of that interest to the other directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A director need not declare an interest:

34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.9.2 if, or to the extent that, the directors are already aware of it;

34.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:

(a) by a meeting of the Board of Directors; or

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

34.10 A matter shall have been authorised for the purposes of paragraph 34.2.2 if:

34.10.1 the Board of Directors by majority disapplies the provision of the Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

34.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

34.10.3 the director's conflict of interest arises from a permitted clause (as determined by the Board of Directors) from time to time.

35. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

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

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

36. REGISTERS

36.1 The Trust shall have:

36.1.1 a register of Members showing, in respect of each Member, the Constituency to which they belong and, where there are classes within it, the class to which they belong;

36.1.2 a Register of Members of the Council of Governors;

36.1.3 a Register of Interests of Governors;

36.1.4 a Register of Directors; and

36.1.5 a Register of Interests of the Directors.

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

37. ADMISSION TO AND REMOVAL FROM THE REGISTERS

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

38. REGISTERS – INSPECTION AND COPIES

38.1 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member, if the Member so requests.

38.2 So far as the registers are required to be made available:

38.2.1 they are to be available for inspection free of charge at all reasonable times; and

38.2.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

38.3 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

39. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

39.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

39.1.1 a copy of the current constitution;

39.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

39.1.3 a copy of the latest Annual Report.

39.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

39.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

39.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

39.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

39.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

39.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

39.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA

(NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

39.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

39.2.8 a copy of any final report published under section 65I (administrator's final report),

39.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

39.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

39.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

40. AUDITOR

40.1 The Trust shall have an auditor.

40.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40.3 A person may only be appointed as the auditor if they (or, in the case of a firm, each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of schedule 7 to the 2006 Act.

40.4 The auditor is to carry out their duties in accordance with schedule 10 to the 2006 Act.

41. AUDIT COMMITTEE

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

42. ACCOUNTS

42.1 The Trust must keep proper accounts and proper records in relation to the accounts.

42.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

42.3 The accounts are to be audited by the Trust's auditor.

42.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

42.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

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

43.1 The Trust shall prepare an Annual Report and send it to NHS England.

43.2 The Annual Report must

43.2.1 review the extent to which the Trust has exercised its functions in accordance with the plans published under:

(a) section 14Z52 of the 2006 Act (joint forward plans for integrated care board and its partners); and

(b) section 14Z56 of the 2006 Act (joint capital resource use plan for integrated care board and its partners),

43.2.2 review the extent to which the Trust has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) of the 2006 Act (views about how functions relating to inequalities information should be exercised);

43.2.3 give information:

(a) on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

(b) on any occasions in the period to which the report relates on which the council of governors exercised its power under paragraph 10C of schedule 7 to the 2006 Act;

(c) on the remuneration of the directors and on the expenses of the Governors and the directors;

(d) on the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had on the provision by the Trust of goods and services for those purposes; and

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

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

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

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

43.6 Each forward plan must include information about:

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

43.6.2 the income it expects to receive from doing so.

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

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

43.7.2 notify the directors of the Trust and its determination.

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

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

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

44.1.1 the annual accounts

44.1.2 any report of the auditor on them

44.1.3 the Annual Report.

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

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

45. INSTRUMENTS

45.1 The Trust shall have a seal.

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

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

46. AMENDMENT OF THE CONSTITUTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

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

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

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

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

(a) the total asset test; or

(b) the total income test; or

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

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

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

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

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

47.4 A transaction:

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

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

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

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

47.5.1 the total asset test; or

47.5.2 the total income test; or

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

where the definitions set out in paragraph 47.2 will apply, except that instead of the threshold being 25% it shall be "greater than 10%".

48. ELECTRONIC COMMUNICATIONS

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

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

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

48.4 The minutes of a meeting held in this way must state that it was held by electronic means and that all persons were all able to hear each other and were present throughout the meeting.

48.5 Meetings open to the public, if held by electronic means, should be open to public attendance by such means.

48.6 For the purposes of this paragraph "electronic means" shall include telephone, video conference or any other such electronic methods, which allows all participating persons in the meeting to hear and interact with each other.

49. INDEMNITY

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

50. DEFECTIVE APPOINTMENTS

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

ANNEX 1

THE PUBLIC CONSTITUENCIES

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

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

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

ANNEX 2
THE STAFF CONSTITUENCY

The Staff Constituency is divided into five (5) classes as follows:

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

ANNEX 3

COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors is to comprise:

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

ANNEX 4

Additional Provisions – Council of Governors

1. Elected Governors

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

2. Appointed Governors

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

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

3. Lead Governor

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

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

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

4. Further provisions as to eligibility to be a Governor

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

4.1.1 they are not a Member;

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

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

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

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

name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

4.1.6 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

4.1.7 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

4.1.8 they are the spouse, partner, parent, child of, or occupant of the same household as a director or a member of the Council of Governors;

4.1.9 they are a member of a local authority's Overview and Scrutiny Committee covering health matters or hold a role at a local authority which involves the review or scrutiny of health matters;

4.1.10 they are a director of the Trust;

4.1.11 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another NHS Body, unless they are appointed by an appointing organisation which is a NHS Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust in exceptional circumstances;

4.1.12 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a NHS Body;

4.1.13 they are a person whose tenure of office as a Chair or as a member or director of a NHS Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

4.1.14 they have previously been removed as a Governor of the Trust;

4.1.15 they have previously been removed as a governor from another NHS foundation trust;

4.1.16 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of any Governor Code of Conduct;

4.1.17 they have committed a serious breach of the Governor Code of Conduct;

4.1.18 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

4.1.19 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

4.1.20 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales, and they have not subsequently had their name included in such a list;

4.1.21 they are deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause; or

4.1.22 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.

4.2 For the purposes of this Annex 4 "a vexatious or persistent complainant" shall be as defined in the Trust's Feedback Complaints and Patient Advice and Liaison (PALS) Policy (or such other policy that may replace it from time to time). In the event of a dispute regarding whether an individual is a vexatious or persistent complainant, the Chair in consultation with the Senior Independent Director shall make the final decision.

4.3 A person holding office as a Governor shall immediately cease to do so if:

4.3.1 they resign by notice in writing to the Secretary;

4.3.2 they become disqualified from office under paragraph 17 of this Constitution or under paragraph 4.1 of this Annex 4;

4.3.3 they fail to attend two meetings of the Council of Governors in a period of one year unless the Lead Governor, Chair and Secretary are satisfied that:

4.3.3.1 the absence was due to a reasonable cause; and

4.3.3.2 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Lead Governor, Chair and Secretary are satisfied that the refusal was due to a reasonable cause; or

4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph 5 below.

4.4 For the purposes of 4.3.3.1 and 4.3.4:

4.4.1 an absence will ordinarily be considered to be due to a reasonable cause if it is due to:

4.4.1.1 a conflict with work or personal commitments in circumstances where the Trust has changed the date of the meeting of the Council of Governors at short notice;

4.4.1.2 ill health (provided that the Governor in question, or someone on their behalf, has advised the Secretary of such circumstances as soon as reasonably practicable); or

4.4.1.3 a personal or family emergency.

4.4.2 For the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors at short notice.

4.4.3 Instances of ill health will be reviewed on a case-by-case basis in consultation between the Lead Governor, Secretary, the Chair and the affected Governor with a view of acting in the best interests of the Trust.

4.5 Where a Governor becomes disqualified for appointment under this paragraph 4 or paragraph 17 of this Constitution, they shall notify the Secretary in writing without delay upon becoming aware the grounds for disqualification. Any failure to notify the Secretary of grounds for disqualification pursuant to this paragraph 4.5 shall result in such individual becoming ineligible to become a Governor at any future point.

4.6 If it comes to the notice of the Secretary that at the time of their appointment or later a Governor is disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of Governor from office

5.1 A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governor present and voting on the grounds that:

5.1.1 they have acted in a manner detrimental to the interests of the Trust or otherwise bring the Trust into disrepute; or

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

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

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

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

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

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

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

6. Vacancies amongst Governors

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

Appointed Governors

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

Elected Governors

6.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:

6.3.1 to call an election within three months to fill the seat for the remainder of that term of office;

6.3.2 to call an election to fill the seat for a new term of office;

6.3.3 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office; or

6.3.4 if the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.

6.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

7. Dispute Resolution

7.1 In the event of any dispute between the Council of Governors and the Board of Directors:

7.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

7.1.2 if the Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

7.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

ANNEX 5

Additional Provisions – Board of Directors

1. **Disqualification of directors**

1.1 In addition to paragraph 26 of this Constitution, a person may not become or continue as a Director if:

1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.2 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

1.1.3 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

1.1.4 they are the spouse, partner, parent, child of, or occupant of the same household as a Director or a member of Council of Governors;

1.1.5 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

1.1.6 they are a Governor;

1.1.7 they are a governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another NHS Body, unless:

1.1.7.1 in the case of an executive director other than the Chief Executive, the Chair, following consultation with the Chief Executive;

1.1.7.2 in the case of the Chief Executive, the Chair, following consultation with the Board of Directors;

1.1.7.3 in the case of a non-executive director other than the Chair, the Chair following consultation with the Council of Governors; or

1.1.7.4 in the case of the Chair, the Senior Independent Director, following consultation with the Board of Directors and the Council of Governors,

agrees to them becoming, or continuing as, a Director;

1.1.8 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

1.1.9 in the case of a non-executive Director, they have refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;

1.1.10 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Director;

1.1.11 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

1.1.12 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;

1.1.13 they are deemed a vexatious or persistent complainant (as defined in Annex 4) or litigant against the Trust without reasonable cause;

1.1.14 they have failed to repay (without good cause) any amount of monies properly owed to the Trust; or

1.1.15 they fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

1.2 Where a Director becomes disqualified for appointment under paragraph 1 of this Annex or paragraph 26 of this Constitution, they shall notify the Trust Secretary in writing of such disqualification.

1.3 If it comes to the notice of the Trust Secretary that at the time of their appointment or later the Director is so disqualified, they shall immediately declare that the Director in question is disqualified and notify them in writing to that effect.

1.4 Where a Director is disqualified their tenure of office shall automatically terminate and they shall cease to hold office with immediate effect.

2. Expenses

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

ANNEX 6

Further Provisions - Membership

1. Restriction on membership

1.1 In addition to paragraph 12 of this Constitution, the following restrictions on Membership apply:

1.1.1 The following will not be eligible to become or continue a Member:

1.1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.1.2 an individual who exhibits inappropriate conduct (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors), including those who have been identified as the perpetrators of a serious incident involving violence, assault or harassment against Trust staff; and/or

1.1.1.3 a person who is a deemed a vexatious or persistent complainant or litigant against the Trust (as defined in Annex 4) without reasonable cause (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors).

2. Termination of Membership

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice in writing to the Trust Secretary;

2.1.2 they cease to be eligible to continue to as a Member under paragraph 1.1.1 of this Annex 6 or paragraph 12 of this Constitution;

2.1.3 they are expelled from Membership under paragraph 1.1 of this Annex 6; or

2.1.4 they die.

2.2 The Trust shall give any Member at least fourteen days' written notice of a proposal to remove them from the Trust membership under this paragraph 2 of Annex 6. The Trust shall consider any representations made by the Member during that notice period, and the Secretary shall decide whether to remove the Member. Within fourteen days after

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

2.3 An individual member removed under paragraph 2.2 may make a request to the Secretary that their membership removal be reviewed and their eligibility to be a member be considered no sooner than 12 months from the date of the removal.

2.4 When making a request under paragraph 2.3 the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request. The Trust's decision shall be final and any further requests for review may only be made after intervals of at least two further years.

ANNEX 7

Annual Members Meeting

1.1 The Trust shall hold a members' meeting for all Members (called the **Annual Members Meeting**) within six months of the end of the financial year of the Trust.

1.2 Any members' meeting other than the Annual Members' Meeting shall be called a 'Special Members Meeting'.

1.3 Both Annual Members' Meetings and Special Members' Meetings shall be open to all Members, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisor's whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

1.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.

1.5 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the Agenda shall be considered at any members' meeting.

1.6 The Board of Directors (or at least one (1) member of the Board of Directors) shall present to the members of the Annual Members' Meeting:

1.6.1 the annual accounts;

1.6.2 any report of the auditor on them;

1.6.3 the Annual Report;

1.6.4 a report on steps taken to secure that (taken as a whole) the actual membership of the Trust is representative of those eligible for such membership;

1.6.5 the progress of the membership plan; and

1.6.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required.

1.7 The Trust shall give notice of all members' meetings:

1.7.1 by notice prominently displayed at the Trust's headquarters;

1.7.2 by notice on the Trust's website;

1.7.3 by notice communicated by email to the Members; and

1.7.4 to the Council of Governors, Board of Directors and the Trust's Auditors, stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).

1.8 Accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.9 The Chair or in their absence, the Vice Chair, shall preside at all members' meetings of the Trust. If neither the Chair not the Vice Chair is present, the Governors present shall elect one of the Non-Executive Directors to act as Chair. If no Non-Executive Director is present, the Governors present shall elect one of their number to act as the meeting Chair. In no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.

1.10 The quorum for a members' meeting shall be twenty (20) members present and entitled to vote. If a quorum is not present within thirty (30) minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven (7) days until such time as the Board of Directors determine.

1.11 No such meeting shall become incompetent to transact business by lack of a quorum arising after the chair has been taken.

1.12 The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.

1.13 A resolution put to the vote at a members' meeting shall be decided on a show of hands.

1.14 Every Member registered who is present shall have one vote. No proxies will be admissible.

1.15 The Trust's Auditor shall act as scrutineers in event of any voting.

1.16 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.17 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date, and/or place.

1.18 Unless exceptional circumstances apply, in the case of a members' meeting is adjourned or postponed for fourteen (14) days or more, at least seven (7) working days' notice shall be given, specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

1.19 The Board of Directors may make any such arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.

1.20 Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. No proposal, speech or any reply may exceed three (3) minutes unless the Chair directs otherwise. In the interests of time, the Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one members' meeting.

1.21 A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply or (ii) on a point of order, or (iii) at the Chair's discretion.

1.22 The ruling of the Chair on any matter of procedure or a point of order shall be final.

ANNEX 8

Model Election Rules

[To be inserted into final copy]

Torbay and South Devon NHS Foundation Trust

Constitution

[DRAFT FOR COUNCIL OF GOVERNORS]

Approved on [INSERT DATE OF FINAL APPROVAL]

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1. DEFINITIONS AND INTERPRETATION

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.2 References to legislation include all regulations, statutory guidance or directions. Headings are for ease of reference only and are not to affect interpretation.

1.3 In this Constitution the following definitions apply:

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

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

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

2. NAME

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

3. PRINCIPAL PURPOSE

3.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in paragraph 3.3 above for the purpose of making additional income available in order to better carry on its Principal Purpose.

4. POWERS

4.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act.

4.2 In the exercise of its powers the Trust shall have regard to:

4.2.1 section 63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the “Triple Aim”;

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

4.2.3 guidance published by NHS England.

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

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

5. JOINT WORKING WITH RELEVANT BODIES

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

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

6. JOINT FINANCIAL OBJECTIVES

6.1 The Trust must:

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

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

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

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

7. MEMBERSHIP AND CONSTITUENCIES

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

7.1.1 a Public Constituency; or

7.1.2 a Staff Constituency.

8. APPLICATION FOR MEMBERSHIP

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

9. PUBLIC CONSTITUENCY

9.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

9.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

9.3 The minimum number of members in each Public Constituency is specified in Annex 1.

10. STAFF CONSTITUENCY

10.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided that they:

10.1.1 are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

10.1.2 have been continuously employed by the Trust under contract of employment for at least 12 months.

10.2 For the purposes of this paragraph 10, Chapter 1 of Part XIV of the Employment Rights Act 1996 (Continuous Employment) shall apply when determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the Trust.

10.3 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

10.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

10.5 The Staff Constituency shall be divided into descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

10.6 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

10.7 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

11. AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

11.1 An individual who is:

11.1.1 eligible to become a member of the Staff Constituency, and

11.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

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

12. RESTRICTION ON MEMBERSHIP

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual must be at least fourteen years old to become a Member.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member are set out in Annex 6.

13. ANNUAL MEMBERS' MEETING

13.1 The Trust shall hold an annual meeting of its members (the **Annual Members' Meeting**). The Annual Members' Meeting shall be open to members of the public.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 7.

14. COUNCIL OF GOVERNORS – COMPOSITION

14.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

15.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules.

15.2 The Model Election Rules as published from time to time form part of this Constitution. The Model Election Rules current at the date of this Constitution are set out at Annex 8.

15.3 A subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46. An updated version of the Constitution may be published by the Secretary incorporating any revised Model Election Rules.

15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

16.1 Elected Governors

16.1.1 An Elected Governor may hold office for a period of up to three years.

16.1.2 An Elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

16.1.3 Subject to paragraph 16.1.4, an Elected Governor shall be eligible for re-election at the end of their term.

16.1.4 An Elected Governor may not serve on the Council of Governors for more than nine years in aggregate. For the avoidance of doubt, this covers all constituencies such that once an Elected Governor has served for nine years in any one constituency or across a mixture of several Constituencies they are no longer eligible to stand for election in any constituency or be appointed to the Council of Governors.

16.2 Appointed Governors

16.2.1 An Appointed Governor may hold office for a term of up to three years.

16.2.2 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

16.2.3 An Appointed Governor shall be eligible for re-appointment at the end of their term.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

17.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or

17.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

17.2 Governors must be at least sixteen years (16) of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor are set out in Annex 4.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

18.1 The general duties of the Council of Governors are to:

18.1.1 hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;

18.1.2 represent the interests of the Members as a whole and the interests of the public; and

18.1.3 feedback information about the Trust, its vision and its performance to Members, the public and stakeholder organisations.

18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1 The Chair, or, in their absence the Vice Chair, shall preside at meetings of the Council of Governors.

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

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

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

20. COUNCIL OF GOVERNORS – STANDING ORDERS

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

21. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

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

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

22. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

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

23. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

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

24. BOARD OF DIRECTORS – COMPOSITION

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

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair

24.2.2 Non-Executive Directors; and

24.2.3 Executive Directors.

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

24.4 The Chief Executive shall be the Accounting Officer.

24.5 One of the Executive Directors shall be the finance director

24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24.8 At least half of the Board of Directors (excluding the Chair) should be Non-executive Directors. In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in their absence, the Vice Chair), shall have a casting vote at meetings of the Board of Directors.

24.9 The post of an Executive Director may be held by two individuals (provided that the provisions of this paragraph 24 are met in respect of required qualifications) on a job share basis. Where such an agreement is in force the two individuals may only exercise one vote between them at any meeting of the Board of Directors. In the case of disagreements, no vote may be cast.

24.10 The Trust may appoint other individuals who may receive a standing invite to attend meetings of the Board of Directors but such individuals shall not be members of the Board of Directors, shall not have a vote and shall not count towards any quorum requirements.

25. BOARD OF DIRECTORS – GENERAL DUTY

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

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

26.1 A person may be appointed as a Non-Executive Director only if

26.1.1 they are a member of a Public Constituency, or

26.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and

26.1.3 they are not disqualified by virtue of paragraph 31 below.

26.2 On first appointment, re-appointment for each further term and throughout their term of office, the Chair and Non-Executive Directors are required to meet the Independence Criteria. In circumstances where, in relation to the Chair or a Non-Executive Director, the Independence Criteria are not met but the Board of Directors considers that the individual in question is independent this will be explained in the Annual Report.

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

27.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the Provider Code of Governance.

27.2 Removal of the Chair or another Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.

27.3 Subject always to the Provider Code of Governance, the maximum tenure for any individual holding the office of Non-Executive Director shall be nine years in aggregate unless exceptional circumstances apply. For the avoidance of doubt, exceptional circumstances shall be determined on a case by case basis.

27.4 In a situation where a Non-Executive Director becomes the Chair, the maximum tenure runs from the time of first appointment to the position of Non-Executive Director.

28. BOARD OF DIRECTORS – APPOINTMENT OF VICE CHAIR

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chair.

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

29. BOARD OF DIRECTORS – APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

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

29.2 The Senior Independent Director will be available to Governors if they have concerns that the Chair is unable to resolve.

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

30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

30.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

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

31. BOARD OF DIRECTORS – DISQUALIFICATION

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

31.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

31.1.2 a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

31.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or

31.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

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

32. BOARD OF DIRECTORS – MEETINGS

32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Minutes of meetings of the Board of Directors held in private shall be provided as required by the Provider Code of Governance unless exceptional circumstances apply which shall be determined on a case by case basis.

33. BOARD OF DIRECTORS – STANDING ORDERS

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

34. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

34.1 The duties that a director of the Trust has by virtue of being a director include in particular:

34.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in paragraph 34.1.1 is not infringed if:

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 the matter has been authorised in accordance with this Constitution.

34.3 The duty referred to in paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In paragraph 34.1.2, "third party" means a person other than:

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

34.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extend of that interest to the other directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A director need not declare an interest:

34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.9.2 if, or to the extent that, the directors are already aware of it;

34.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:

(a) by a meeting of the Board of Directors; or

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

34.10 A matter shall have been authorised for the purposes of paragraph 34.2.2 if:

34.10.1 the Board of Directors by majority disapplies the provision of the Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

34.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

34.10.3 the director's conflict of interest arises from a permitted clause (as determined by the Board of Directors) from time to time.

35. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

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

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

36. REGISTERS

36.1 The Trust shall have:

36.1.1 a register of Members showing, in respect of each Member, the Constituency to which they belong and, where there are classes within it, the class to which they belong;

36.1.2 a Register of Members of the Council of Governors;

36.1.3 a Register of Interests of Governors;

36.1.4 a Register of Directors; and

36.1.5 a Register of Interests of the Directors.

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

37. ADMISSION TO AND REMOVAL FROM THE REGISTERS

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

38. REGISTERS – INSPECTION AND COPIES

38.1 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member, if the Member so requests.

38.2 So far as the registers are required to be made available:

38.2.1 they are to be available for inspection free of charge at all reasonable times; and

38.2.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

38.3 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

39. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

39.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

39.1.1 a copy of the current constitution;

39.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

39.1.3 a copy of the latest Annual Report.

39.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

39.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

39.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

39.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

39.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

39.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

39.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

39.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

39.2.8 a copy of any final report published under section 65I (administrator's final report),

39.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

39.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

39.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

40. AUDITOR

40.1 The Trust shall have an auditor.

40.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40.3 A person may only be appointed as the auditor if they (or, in the case of a firm, each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of schedule 7 to the 2006 Act.

40.4 The auditor is to carry out their duties in accordance with schedule 10 to the 2006 Act.

41. AUDIT COMMITTEE

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

42. ACCOUNTS

42.1 The Trust must keep proper accounts and proper records in relation to the accounts.

42.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

42.3 The accounts are to be audited by the Trust's auditor.

42.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

42.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

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

43.1 The Trust shall prepare an Annual Report and send it to NHS England.

43.2 The Annual Report must

43.2.1 review the extent to which the Trust has exercised its functions in accordance with the plans published under:

(a) section 14Z52 of the 2006 Act (joint forward plans for integrated care board and its partners); and

(b) section 14Z56 of the 2006 Act (joint capital resource use plan for integrated care board and its partners),

43.2.2 review the extent to which the Trust has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) of the 2006 Act (views about how functions relating to inequalities information should be exercised);

43.2.3 give information:

(a) on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

(b) on any occasions in the period to which the report relates on which the council of governors exercised its power under paragraph 10C of schedule 7 to the 2006 Act;

(c) on the remuneration of the directors and on the expenses of the Governors and the directors;

(d) on the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had on the provision by the Trust of goods and services for those purposes; and

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

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

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

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

43.6 Each forward plan must include information about:

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

43.6.2 the income it expects to receive from doing so.

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

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

43.7.2 notify the directors of the Trust and its determination.

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

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

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

44.1.1 the annual accounts

44.1.2 any report of the auditor on them

44.1.3 the Annual Report.

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

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

45. INSTRUMENTS

45.1 The Trust shall have a seal.

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

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

46. AMENDMENT OF THE CONSTITUTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

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

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

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

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

(a) the total asset test; or

(b) the total income test; or

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

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

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

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

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

47.4 A transaction:

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

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

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

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

47.5.1 the total asset test; or

47.5.2 the total income test; or

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

where the definitions set out in paragraph 47.2 will apply, except that instead of the threshold being 25% it shall be “greater than 10%”.

48. ELECTRONIC COMMUNICATIONS

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

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

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

48.4 The minutes of a meeting held in this way must state that it was held by electronic means and that all persons were all able to hear each other and were present throughout the meeting.

48.5 Meetings open to the public, if held by electronic means, should be open to public attendance by such means.

48.6 For the purposes of this paragraph "electronic means" shall include telephone, video conference or any other such electronic methods, which allows all participating persons in the meeting to hear and interact with each other.

49. INDEMNITY

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

50. DEFECTIVE APPOINTMENTS

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

ANNEX 1

THE PUBLIC CONSTITUENCIES

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

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

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

ANNEX 2
THE STAFF CONSTITUENCY

The Staff Constituency is divided into five (5) classes as follows:

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

ANNEX 3

COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors is to comprise:

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

ANNEX 4

Additional Provisions – Council of Governors

1. Elected Governors

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

2. Appointed Governors

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

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

3. Lead Governor

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

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

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

4. Further provisions as to eligibility to be a Governor

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

4.1.1 they are not a Member;

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

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

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

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

name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

4.1.6 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

4.1.7 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

4.1.8 they are the spouse, partner, parent, child of, or occupant of the same household as a director or a member of the Council of Governors;

4.1.9 they are a member of a local authority's Overview and Scrutiny Committee covering health matters or hold a role at a local authority which involves the review or scrutiny of health matters;

4.1.10 they are a director of the Trust;

4.1.11 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another NHS Body, unless they are appointed by an appointing organisation which is a NHS Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust in exceptional circumstances;

4.1.12 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a NHS Body;

4.1.13 they are a person whose tenure of office as a Chair or as a member or director of a NHS Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

4.1.14 they have previously been removed as a Governor of the Trust;

4.1.15 they have previously been removed as a governor from another NHS foundation trust;

4.1.16 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of any Governor Code of Conduct;

4.1.17 they have committed a serious breach of the Governor Code of Conduct;

4.1.18 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

4.1.19 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

4.1.20 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales, and they have not subsequently had their name included in such a list;

4.1.21 they are deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause; or

4.1.22 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.

4.2 For the purposes of this Annex 4 "a vexatious or persistent complainant" shall be as defined in the Trust's Feedback Complaints and Patient Advice and Liaison (PALS) Policy (or such other policy that may replace it from time to time). In the event of a dispute regarding whether an individual is a vexatious or persistent complainant, the Chair in consultation with the Senior Independent Director shall make the final decision.

4.3 A person holding office as a Governor shall immediately cease to do so if:

4.3.1 they resign by notice in writing to the Secretary;

4.3.2 they become disqualified from office under paragraph 17 of this Constitution or under paragraph 4.1 of this Annex 4;

4.3.3 they fail to attend two meetings of the Council of Governors in a period of one year unless the Lead Governor, Chair and Secretary are satisfied that:

4.3.3.1 the absence was due to a reasonable cause; and

4.3.3.2 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Lead Governor, Chair and Secretary are satisfied that the refusal was due to a reasonable cause; or

4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph 5 below.

4.4 For the purposes of 4.3.3.1 and 4.3.4:

4.4.1 an absence will ordinarily be considered to be due to a reasonable cause if it is due to:

4.4.1.1 a conflict with work or personal commitments in circumstances where the Trust has changed the date of the meeting of the Council of Governors at short notice;

4.4.1.2 ill health (provided that the Governor in question, or someone on their behalf, has advised the Secretary of such circumstances as soon as reasonably practicable); or

4.4.1.3 a personal or family emergency.

4.4.2 For the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors at short notice.

4.4.3 Instances of ill health will be reviewed on a case-by-case basis in consultation between the Lead Governor, Secretary, the Chair and the affected Governor with a view of acting in the best interests of the Trust.

4.5 Where a Governor becomes disqualified for appointment under this paragraph 4 or paragraph 17 of this Constitution, they shall notify the Secretary in writing without delay upon becoming aware the grounds for disqualification. Any failure to notify the Secretary of grounds for disqualification pursuant to this paragraph 4.5 shall result in such individual becoming ineligible to become a Governor at any future point.

4.6 If it comes to the notice of the Secretary that at the time of their appointment or later a Governor is disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of Governor from office

5.1 A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governor present and voting on the grounds that:

5.1.1 they have acted in a manner detrimental to the interests of the Trust or otherwise bring the Trust into disrepute; or

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

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

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

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

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

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

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

6. Vacancies amongst Governors

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

Appointed Governors

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

Elected Governors

6.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:

6.3.1 to call an election within three months to fill the seat for the remainder of that term of office;

6.3.2 to call an election to fill the seat for a new term of office;

6.3.3 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office; or

6.3.4 if the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.

6.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

7. Dispute Resolution

7.1 In the event of any dispute between the Council of Governors and the Board of Directors:

7.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

7.1.2 if the Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

7.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

ANNEX 5

Additional Provisions – Board of Directors

1. **Disqualification of directors**

1.1 In addition to paragraph 26 of this Constitution, a person may not become or continue as a Director if:

1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.2 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

1.1.3 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

1.1.4 they are the spouse, partner, parent, child of, or occupant of the same household as a Director or a member of Council of Governors;

1.1.5 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

1.1.6 they are a Governor;

1.1.7 they are a governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another NHS Body, unless:

1.1.7.1 in the case of an executive director other than the Chief Executive, the Chair, following consultation with the Chief Executive;

1.1.7.2 in the case of the Chief Executive, the Chair, following consultation with the Board of Directors;

1.1.7.3 in the case of a non-executive director other than the Chair, the Chair following consultation with the Council of Governors; or

1.1.7.4 in the case of the Chair, the Senior Independent Director, following consultation with the Board of Directors and the Council of Governors,

agrees to them becoming, or continuing as, a Director;

1.1.8 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

1.1.9 in the case of a non-executive Director, they have refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;

1.1.10 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Director;

1.1.11 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

1.1.12 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;

1.1.13 they are deemed a vexatious or persistent complainant (as defined in Annex 4) or litigant against the Trust without reasonable cause;

1.1.14 they have failed to repay (without good cause) any amount of monies properly owed to the Trust; or

1.1.15 they fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

1.2 Where a Director becomes disqualified for appointment under paragraph 1 of this Annex or paragraph 26 of this Constitution, they shall notify the Trust Secretary in writing of such disqualification.

1.3 If it comes to the notice of the Trust Secretary that at the time of their appointment or later the Director is so disqualified, they shall immediately declare that the Director in question is disqualified and notify them in writing to that effect.

1.4 Where a Director is disqualified their tenure of office shall automatically terminate and they shall cease to hold office with immediate effect.

2. Expenses

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

ANNEX 6

Further Provisions - Membership

1. Restriction on membership

1.1 In addition to paragraph 12 of this Constitution, the following restrictions on Membership apply:

1.1.1 The following will not be eligible to become or continue a Member:

1.1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.1.2 an individual who exhibits inappropriate conduct (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors), including those who have been identified as the perpetrators of a serious incident involving violence, assault or harassment against Trust staff; and/or

1.1.1.3 a person who is a deemed a vexatious or persistent complainant or litigant against the Trust (as defined in Annex 4) without reasonable cause (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors).

2. Termination of Membership

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice in writing to the Trust Secretary;

2.1.2 they cease to be eligible to continue to as a Member under paragraph 1.1.1 of this Annex 6 or paragraph 12 of this Constitution;

2.1.3 they are expelled from Membership under paragraph 1.1 of this Annex 6; or

2.1.4 they die.

2.2 The Trust shall give any Member at least fourteen days' written notice of a proposal to remove them from the Trust membership under this paragraph 2 of Annex 6. The Trust shall consider any representations made by the Member during that notice period, and the Secretary shall decide whether to remove the Member. Within fourteen days after receiving notice of the Secretary's decision, a person wishing to dispute

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

2.3 An individual member removed under paragraph 2.2 may make a request to the Secretary that their membership removal be reviewed and their eligibility to be a member be considered no sooner than 12 months from the date of the removal.

2.4 When making a request under paragraph 2.3 the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request. The Trust's decision shall be final and any further requests for review may only be made after intervals of at least two further years.

ANNEX 7

Annual Members Meeting

1.1 The Trust shall hold a members' meeting for all Members (called the **Annual Members Meeting**) within six months of the end of the financial year of the Trust.

1.2 Any members' meeting other than the Annual Members' Meeting shall be called a 'Special Members Meeting'.

1.3 Both Annual Members' Meetings and Special Members' Meetings shall be open to all Members, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisor's whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

1.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.

1.5 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the Agenda shall be considered at any members' meeting.

1.6 The Board of Directors (or at least one (1) member of the Board of Directors) shall present to the members of the Annual Members' Meeting:

1.6.1 the annual accounts;

1.6.2 any report of the auditor on them;

1.6.3 the Annual Report;

1.6.4 a report on steps taken to secure that (taken as a whole) the actual membership of the Trust is representative of those eligible for such membership;

1.6.5 the progress of the membership plan; and

1.6.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required.

1.7 The Trust shall give notice of all members' meetings:

1.7.1 by notice prominently displayed at the Trust's headquarters;

1.7.2 by notice on the Trust's website;

1.7.3 by notice communicated by email to the Members; and

1.7.4 to the Council of Governors, Board of Directors and the Trust's Auditors, stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).

1.8 Accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.9 The Chair or in their absence, the Vice Chair, shall preside at all members' meetings of the Trust. If neither the Chair not the Vice Chair is present, the Governors present shall elect one of the Non-Executive Directors to act as Chair. If no Non-Executive Director is present, the Governors present shall elect one of their number to act as the meeting Chair. In no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.

1.10 The quorum for a members' meeting shall be twenty (20) members present and entitled to vote. If a quorum is not present within thirty (30) minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven (7) days until such time as the Board of Directors determine.

1.11 No such meeting shall become incompetent to transact business by lack of a quorum arising after the chair has been taken.

1.12 The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.

1.13 A resolution put to the vote at a members' meeting shall be decided on a show of hands.

1.14 Every Member registered who is present shall have one vote. No proxies will be admissible.

1.15 The Trust's Auditor shall act as scrutineers in event of any voting.

1.16 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.17 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting

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

1.18 Unless exceptional circumstances apply, in the case of a members' meeting is adjourned or postponed for fourteen (14) days or more, at least seven (7) working days' notice shall be given, specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

1.19 The Board of Directors may make any such arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.

1.20 Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. No proposal, speech or any reply may exceed three (3) minutes unless the Chair directs otherwise. In the interests of time, the Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one members' meeting.

1.21 A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply or (ii) on a point of order, or (iii) at the Chair's discretion.

1.22 The ruling of the Chair on any matter of procedure or a point of order shall be final.

ANNEX 8

Model Election Rules

[To be inserted into final copy]

Summary Report	
Title	**compareDocs Comparison Results**
Date & Time	17/10/2023 16:14:45
Comparison Time	1.23 seconds
compareDocs version	v5.1.500.8

Sources	
Original Document	[Active1][#152199666] [v1] 2023 10 10 DRAFT Constitution.docx
Modified Document	[Active1][#152327670] [v1] 2023 10 17 DRAFT Constitution.docx

Comparison Statistics	
Insertions	2
Deletions	1
Changes	2
Moves	0
Font Changes	0
Paragraph Style Changes	0
Character Style Changes	0
TOTAL CHANGES	5

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Insertions	
~~Deletions~~	
Moves / ~~Moves~~	
Font Changes	
Paragraph Style Changes	
Character Style Changes	
Inserted cells	
Deleted cells	
Merged cells	
Changed lines	Mark left border.

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Character Level	Word	True
Include Comments	Word	True
Include Field Codes	Word	True
Flatten Field Codes	Word	True
Include Footnotes / Endnotes	Word	True
Include Headers / Footers	Word	True
Image compare mode	Word	Insert/Delete
Include List Numbers	Word	True
Include Quotation Marks	Word	False
Show Moves	Word	False
Include Tables	Word	True
Include Text Boxes	Word	True
Show Reviewing Pane	Word	True
Summary Report	Word	End
Detail Report	Word	Separate (View Only)
Document View	Word	Print

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Foundation Trust Network

Model Election Rules 2014

For use in elections to FT councils of governors

Lancashire Teaching Hospitals NHS Foundation Trust | Foundation Trust Network

Model Election Rules 2014

Action to be taken before the poll

The poll

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

PART 6 COUNTING THE VOTES

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

Lancashire Teaching Hospitals NHS Foundation Trust | Foundation Trust Network

PART 1 INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of

submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.


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PART 5 CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to

vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer

was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the

next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing

candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any

stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are

excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to

rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10 ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.


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PART 11 QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

The Foundation Trust Network (FTN) is the membership organisation for NHS acute hospitals and community, mental health and ambulance services.

The FTN acts as the public voice for those NHS trusts, helping to deliver high quality care and shaping the system in which they operate.

The FTN has over 227 members – more than 92% of all NHS foundation trusts and aspirant trusts.

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Foundation Trust Network

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. Meetings of the Council of Governors

1.1 The Council of Governors is to meet a minimum of four (4) times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen (14) days' written notice of the date and place of every meeting of the Council of Governor to all Governors. Notice of the Council of Governor's meetings will be made public by whatever communications method the Trust determines.

1.2 Meetings of the Council of Governors may be called by the Secretary, or by the Chair.

1.3 Meetings of the Council of Governors may be called by ten (10) Governors, which shall include at least one (1) elected Governor and one (1) appointed Governor, who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request.

1.4 The Secretary shall call a meeting on at least seven (7) but no more than twenty-eight (28) days' notice.

1.5 If the Secretary fails to call such a meeting following notice pursuant to paragraph 1.3 above then the Chair of ten (10) Governors, which ever is the case, shall call such a meeting.

1.6 At least one-third of Governors shall form quorum for the Council of Governors.

1.7 Meetings of the Council of Governors' shall be chaired by the Trust Chair. On matters concerning the succession of the Chair, the Senior Independent Director will preside.

1.8 The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the auditor or other advisers to attend a meeting of the Council of Governors.

1.9 Any Governor who is unable to attend the Council of Governors meeting should advise the Secretary in advance of the meeting.

1.10 Any Governor who is not able to be present in person may participate in a Council of Governor's meeting by means of conference telephone or any other such electronic means, which allows all participating in the meeting to hear each other. A Governor so participating shall be deemed to be present in person at such meeting and shall be entitled to vote and counted in the quorum. Such a Council of Governor's meeting shall be deemed to take place where the largest group of those participating is assembled, or, if there is no such group, where the Chair is located.

1.11 Subject to the Constitution and the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

1.12 Not used

1.13 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. The Council of Governors may appoint Governors and may invite directors and other persons to serve on such committees. The Council of Governors may, through the Secretary, request that external advisors assist them to any committee they appoint in carrying out its duties.

1.14 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid notwithstanding any vacancy or any defect in the calling of the meeting, or the election or appointment of the Governors attending the meeting.

1.15 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for the whole or part of such meeting in the following circumstances:

1.15.1 where the Council of Governors by resolution decides for reasons of commercial confidentiality for other special reasons arising from the business of the meeting; or

1.15.2 wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

1.16 The Chairman may exclude a member of the public if they are interfering with or preventing the proper conduct of the meeting.

Proposing Council of Governors' motions

1.17 Questions on notice are defined as questions from Governors about matters which are directly in relation to matters over which the Council of Governors had powers or duties, or which affect the services provided by the Trust.

1.18 A Governor may ask a question which is not related to items on the forthcoming Council of Governors' agenda.

1.19 An answer may take the form of: a direct oral answer; where the information is in a publication of the Trust or other published work by reference to that publication; where the reply cannot be conveniently be given orally in the form of a written answer circulated later to the questioner and the Council of Governors; or by brief oral answer supplemented by a written answer circulated later to the questioner and the Council of Governors.

1.20 Approval to speak at Council of Governors' meetings will be given by the Chair. Unless in the opinion of the Chair it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature, complexity and importance, no proposal speech, nor any reply, may exceed three minutes. in the interests of time, the Chair may limit the number of replies which are heard.

1.21 A person who has spoken on a motion may not speak again whilst it is the subject of debate, except in exercise of right of reply, on a point of order, or, at the discretion of the Chair.

1.22 Supplementary questions for clarification may be asked at the discretion of the Chair.

1.23 Motions may only be submitted by Governors and must be received by the Secretary in writing at least fourteen (14) days before the meeting date, together with any relevant supporting paper. Except for motions which can be moved without notice under 1.23, written notice of every motion signed or transmitted by at least two (2) Governors, is required. The Secretary shall acknowledge such motions.

1.24 Urgent motions may be submitted before the commencement of meetings of the Council of Governors, provided that the motions are signed or transmitted by at least two (2) Governors. Consideration of urgent motions shall be at the discretion of the Chair.

1.25 The following motions may be moved without notice: accuracy of the minutes; change the order of business in the agenda; refer something to an appropriate body or individual; appoint a working group arising from an item on the agenda; receive reports or adopt recommendations made by the Board of Directors; withdraw a motion; amend a motion (without substantially altering the intention of the motion); proceed to the next business; that the question now be put; adjourn a debate; adjourn a meeting; suspend a Council of Governors procedure rule (for the duration of the meeting); exclude the public and press; give the consent of the Council of Governors where its consent is required by the Constitution; or, not hear further a Governor or to exclude them from the meeting.

Proposing Council of Governors' Written Resolutions

1.26 The Secretary, the Chair, or ten (10) Governors, including one Elected Governor and one Appointed Governor, who give written notice to the Secretary specifying the business to be carried out may propose a Council of Governors' written resolution.

1.27 The following may not be passed as a written resolution: the removal of a Non-Executive Director or Chair; removal of the auditor; or, approval of a significant transaction.

1.28 A Council of Governors' written resolution is proposed by giving written notice of the proposed resolution to each Governor. Notice by post, delivery in person, fax or email shall constitute written notice.

1.29 Notice of a proposed Council of Governors written resolution must indicate:

1.29.1 the proposed resolution;
1.29.2 how to signify agreement to the resolution; and
1.29.3 the date by which it is proposed that the Council of Governors should adopt it. A proposed written resolution shall lapse if not adopted by the 28th day from circulation.

1.30 References in this paragraph to eligible Governors are to members of the Council of Governors who would have been entitled to vote on the matter had it been proposed at a meeting of the Council of Governors.

1.31 A decision may not be taken in accordance with this paragraph if the eligible governors would not have formed a quorum at such a meeting.

1.32 The resolution is deemed to have been passed when the required majority (simple majority, or 75% majority if a special resolution) as appropriate of eligible Governors have signed their agreement to it.

1.33 Where decisions of the Council of Governors are taken by means other than at a face-to-face meeting or by written resolution, such decisions shall be recorded by the Secretary in permanent written form.

2. Disclosure of interests

2.1 Members of the Council of Governor's shall disclose to the Council of Governor's any material interests as defined below held by a Governor, and shall withdraw from the meeting and play no part in the relevant discussion or decision and shall not vote on the issue (and if advertently they do remain and vote, their vote shall not be counted).

2.2 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

2.3 Subject to the exceptions below, a material interest in a matter is where a Governor:

2.3.1 holds any directorship, including non-executive directorship, (with the exception of dormant companies) of a company;
2.3.2 holds any interest or position in any firm or company or business;
2.3.3 has any interest in an organisation providing health and social care services to the National Health Service; or
2.3.4 holds any position of authority in a charity or voluntary organisation in the field of health and social care;

and such organisation is, in connection with the matter, trading with the Trust or entering into a financial arrangement with the Trust, or is likely to be considered as a potential contractor to the Trust.

2.4 The exceptions which shall not be treated as material interests are as follows:

2.4.1 shares held in any company where the value of those securities does not exceed £25,000 or the number of shares held does not exceed 5% of the total number of issued shares in a company whose shares are listed on any public exchange;
2.4.2 an employment contract with the Trust held by a Staff Governor;
2.4.3 an employment contract with a local authority held by a Local Authority Governor;
2.4.4 an employment contract with a partnership organisation held by a Partnership Governor; or
2.4.5 any travelling or other expenses or allowances payable to a Governor.

3. Declaration

An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the from specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Council of Governors. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors.

4. Council of Governors Committees, Sub-Committees and Groups

4.1 The Council of Governors shall establish a nominations committee for the purpose of discharging its duties in accordance with the 2006 Act and the Provider Code of Governance. The nominations committee will decide the remuneration and allowances and other terms and conditions of office of the Chairman and other non-executive directors.

4.2 The Council of Governors may appoint additional committees consisting of its members to assist it in carrying out its functions. A committee appointed under this paragraph may also appoint a sub-committee.

5. Order of precedence

5.1 If there is any conflict or ambiguity between the terms of the Trust's Constitution and the Provider Code of Governance and these Standing Orders, the following order of precedence shall apply:

5.1.1 Trust's Constitution;

5.1.2 .the Provider Code of Governance;

5.1.3 these Standing Orders.

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Board of Directors Standing Orders

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Document Information

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Amendment History

Issue	Status	Date	Reason for Change	Authorised
0.7	approved	Nov 11	Bribery Act/ Tender process Review	Board
0.8	Draft	Oct 12	Revised hospitality / small gifts arrangements for TP re – trading and competitive status	PMU board
2	Approved	Jan 14	Consistency of version numbering	CoSec
2.1	Draft	Oct 14	Nomenclature and updates re: TP	CoSec/DDF
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3.3	Approved	Aug 15	Updated for ICO	Board
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5.1	Draft	Oct 19	Governance restructure, legislation, procurement rules, delegation limits	Audit & FPD Committee
6	Approved	Oct 20	Changes to authorisation limits of governance groups and individuals	FPDC & Board

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board of Directors) and in the case of Standing Financial Instructions by the Chief Finance Officer and Head of Internal Audit.

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, National Health Service Act 2006, Health and Social Care Act 2012, Care Act 2014or subsequent acts and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in this interpretation and in addition:

1.2.1 **"Accounting Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Foundation Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **“Associate Director”** means a director, who is an officer of the Trust appointed in accordance with the Constitution, allowing full participation in the work of the Board of Directors with the exception of formal voting rights. For the purposes of this document, ‘Associate Director’ shall not include an employee whose job title incorporates the words ‘Associate Director’ but who has not been appointed in this manner.

1.2.3 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board of Directors for them to perform and these duties have been recorded in an appropriate Board of Directors minute or other suitable record.

1.2.4 **"Board of Directors"** means the Board of Directors comprising the Chairman, the Chief Executive, other Executive Directors and other Non-Executive Directors as defined in the Trust’s Constitution.

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1.2.5 **"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.6 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.7 **"Chairman of the Board of Directors"** is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

1.2.8 **"Chief Executive"** means the chief officer of the Trust.

1.2.9 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.10 **"Committee"** means a committee or sub-committee created and appointed by the Trust.

1.2.11 **"Committee members"** means persons formally appointed by the Board of Directors to sit on or to chair specific committees.

1.2.12 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.13 **"Council of Governors"** means that body of elected and appointed Governors, authorised to be members of the Council of Governors and act in accordance with the Constitution.

1.2.14 **"Chief Finance Officer"** means the chief financial officer of the Trust.

1.2.15 **"Executive Director**" means a member of the Trust who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document 'director' shall not include an employee whose job title incorporates the word 'director' but who has not been appointed in this manner.

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1.2.16 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept. Such funds may or may not be charitable.

1.2.17 **"Independent Regulator"** means the Regulator for the purpose of Part 1 of the 2003 Act.

1.2.18 **"Legal Adviser"** means the properly qualified person appointed by the Trust to provide legal advice.

1.2.19 **"Member"** means executive or Non-Executive director of the Board of Directors.

1.2.20 **"Motion"** means a formal proposition to be discussed and voted on during the course of the meeting.

1.2.21 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.22 **"Non-Executive Director"** means a Member of the Board of Directors who does not hold an executive office of the Trust.

1.2.23 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.24 **"Secretary"** means a person appointed by the Trust (the Company Secretary) to act independently of the Board of Directors and monitor the Trust's compliance with the law, SO's and observance of Constitution and Licence.

1.2.25 **"SFIs"** means Standing Financial Instructions.

1.2.26 **"SOs"** means Standing Orders.

1.2.27 **"System Director"** means ISU System Director, System Medical Director or System Director of Nursing and Professional Practice.

1.2.28 **"TP"** means Torbay Pharmaceuticals.

1.2.29 **"Trust"** means Torbay and South Devon NHS Foundation Trust.

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1.2.30 **"Vice-Chairman"** means the non-executive director ratified by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

1.2.31 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer isused in these instructions, it shall be deemed to include such other Director or employee who has been duly authorised to represent them.

1.2.32 Wherever the item "employee" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust. In addition "employee" includes all nursing and medical staff and consultants practising upon Torbay and South Devon NHS Foundation Trust premises or contracted to perform services on other premises on behalf of Torbay and South Devon NHS Foundation Trust.

1.2.33 All references in these Standing Orders to the masculine gender shall be read as equally applicable to the feminine gender and vice versa.

2. Order of precedence

2.1 If there is any conflict or ambiguity between the terms of the Trust's Constitution and the Provider Code of Governance and these Standing Orders, the following order of precedence shall apply:

2.1.1 Trust's Constitution;

2.1.2 .the Provider Code of Governance;

2.1.3 these Standing Orders.

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SECTION B

1. INTRODUCTION

1.1 Statutory Framework

1.1.1 The Torbay and South Devon NHS Foundation Trust is a public benefit corporation which was established originally as South Devon healthcare NHS Foundation Trust under the Health and Social Care (Community Health and Standards) Act 2003 on 1 March 2007 and Changed its name to Torbay and South Devon NHS Foundation Trust on 1st October 2015. NHS Foundation Trusts are governed by statute, mainly the National Health Service Act 2006, Health and Social Care Act 2012 and the National Health Service Act 1977 (NHS Act 1977). The Integrated Care Organisation (ICO) from 1 October 2015 will also need to take into consideration the Care Act 2014 and any subsequent amendments.

1.1.2 NHS Foundation Trusts are governed by statute, mainly the National Health Service Act 2006, and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the National Health Service Act 2006 and in the Trust's Licence and Constitution.

1.1.3 As a public benefit corporation the Trust has specific powers to do anything which is necessary or desirable for the purposes of, or in connection with, its functions. It is also accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.4 The Constitution requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. When compiling their accounts, the Independent Regulator of Foundation Trusts (NHS Improvement/Monitor) requires that foundation trusts comply with International Financial Reporting Standards. NHS Improvement/Monitor has produced a Financial Reporting Manual (FReM) which also provides guidance for foundation trusts, consistent with the requirements of the Financial Reporting Advisory Board.

1.1.5 NHS Improvement/Monitor's Code of Governance requires that, inter alia, boards draw up a schedule of matters reserved to the board, and ensure that management arrangements are in place to

enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The constitution also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Trust also operates a Code of Conduct for directors.

1.2 NHS Framework

1.2.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.3 Delegation of Powers

1.3.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Independent Regulator may direct". Delegated Powers are covered in a separate document (Reservation of Powers to the Board of Directors and Delegation of Powers). This document has effect as if incorporated into the Standing Orders.

1.4 Integrated Governance

1.4.1 Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance has been issued and is incorporated in the Trust's Information Governance Strategy (see Integrated Governance Handbook 2006). Integrated governance enables the Board of Directors to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

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2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Board of Directors

2.1.1 In accordance with the Constitution the composition of the Board of Directors shall be:

a) a Non-Executive Chairman;
b) not less than five and no greater than eight other Non-Executive Directors.
c) a Chief Executive and not less than four and no more than seven Executive Directors; and
d) at least half of the Board of Directors, excluding the Chairman, should be Non-Executive Directors.
e) one of the Executive Directors will be the Chief Executive.
f) the Chief Executive shall be the Accounting Officer.
g) one of the Executive Directors shall be the Chief Finance Officer.
h) one of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).
i) one of the Executive Directors is to be a registered nurse or a registered midwife.
j) the Board of Directors may determine that other Trust officers may attend meetings of the Board of Directors as and when required to provide operational advice and support to the Board to assist the Board in the discharge of their responsibilities. For the avoidance of doubt, such an officer attending will not be a Director for the purpose of the 2006 Act, nor will they be able to vote and will bear no responsibility or liability for any action of decision of the Board of Directors.

2.2 Appointment of the Chairman and Board Directors

2.2.1 The regulations for such appointments are laid down in the Constitution and are summarised as follows. The Chairman and Non-Executive Directors are appointed by the Council of Governors. The Council of Governors shall appoint a committee (the Nominations Committee), whose members shall be laid down in terms of reference, to select suitable candidates for their approval. It is for the Non-Executive Directors to appoint (subject to

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the approval of the Council of Governors) or remove the Chief Executive (and accounting officer). Executive Directors, except for the Chief Executive, will be appointed or removed by a committee whose members shall be the Chairman, the Vice Chairman and the Chief Executive and such other members that are deemed necessary by the Chairman.

2.3 Terms of Office of the Chairman and Directors

2.3.1 The regulations governing the period of tenure of office of the Chairman and directors and the termination or suspension of office of the Chairman and directors are contained in the Constitution.

2.4 Termination of Tenure

2.4.1 If the Chairman or a Non-Executive Director fails to attend three consecutive meetings of the Board of Directors, the Board of Directors shall, by giving notice in writing to the person, remove that person from office unless the Board of Directors (in consultation with the Council of Governors) is satisfied that:

a) the absence was due to a reasonable cause; and
b) they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

2.5 Appointment and Powers of Vice-Chairman

2.5.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Board of Directors will recommend one of the Non-Executive Directors to be the Vice Chairman of the Trust. The Council of Governors will be asked to ratify this recommendation. This appointment as Vice-Chairman will be for a period not exceeding the remainder of his term as Non-Executive Director of the Trust.

2.5.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and Directors of the Trust may thereupon appoint another Non-Executive Director as Vice-Chairman in accordance with the provisions of Standing Order 2.5.1.

2.5.3 Where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Vice-Chairman

shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Vice-Chairman.

2.6 Appointment of Senior Independent Director

2.6.1 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be the Senior Independent Director, using the procedure set out in the Constitution.

2.7 Joint Directors

2.7.1 Where one or more persons is appointed jointly to a post in the Trust which qualifies the holder for executive directorship, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 2.7 as one person.

2.7.2 Where a post of Executive Director of the Board of Directors is shared jointly by more than one person:

a) either or both of those persons may attend or take part in meetings of the Board of Directors;
b) if both are present at a meeting they should cast one vote if they agree;
c) in the case of disagreements no vote should be cast; and
d) the presence of either or both of those persons shall count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.8 Role of Board of Directors

2.8.1 The Board of Directors will function as a corporate decision-making body Officer and Non-Officer (Non–Executive) Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.8.2 Executive Directors

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Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.8.3 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum for Trust Chief Executives.

2.8.4 Chief Finance Officer

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.8.5 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.8.6 Chairman

The Chairman shall be responsible for the operation of the Board of Directors and chair all Board of Directors meetings when present. The Chairman has certain delegated executive powers. The Chairman shall comply with his terms of appointment and with these Standing Orders.

The Chairman shall work with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the debate and ultimate resolutions.

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2.9 Corporate Role of the Trust

2.9.1 All business shall be conducted in the name of the Trust.

2.9.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.9.3 The Trust has the functions conferred on it by the National Health Service Act 2006, and by its Licence, which include the Constitution.

2.9.4 Directors acting on behalf of their Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission. Accountability for non-charitable funds held on trust is to NHS Improvement/Monitor.

2.10 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation

2.10.1 The Trust has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board of Directors' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.11 Lead Roles for members of the Board of Directors

2.11.1 The Chairman will ensure that the designation of 'Lead Roles' or appointments of Board of Directors members as required by the Independent Regulator, NHS Improvement/Monitor or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc.).

2.12 Appointment of Secretary

2.12.1 The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice may also remove the Secretary from that position.

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2.13 Relationship between the Board of Directors and the Council of Governors

2.13.1 The Constitution describes the duties of these two bodies in more detail. In summary the Board of Directors manage the business of the Trust (in accordance with the Constitution), and the Council of Governors conduct a number of tasks, among them; to approve the appointment of the Non-Executive members of the Board of Directors (after selection by the Nominations Committee); to decide their remuneration and terms and conditions of office; to appoint auditors; and to review various periodic reports listed in the constitution, presented to them by the Board of Directors. The Council of Governors will also represent the views of their constituency, or organisation, so that the needs of the local health economy are taken into account when deciding the Trust's strategic direction.

2.13.2 In situations where any conflict arises between the Board of Directors and the Council of Governors, which contact through the normal channels of the Chairman, Chief Executive or Company Secretary has failed to resolve, or for which such contact is inappropriate, the procedure for resolving differences between the Council of Governors and the Board of Directors as described in Regulator guidance will be invoked.

3 MEETINGS OF THE BOARD OF DIRECTORS

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.1.2 The Chairman of the Trust may call a meeting of the Board of Directors at any time.

3.1.3 One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Board of Directors, a written notice of the meeting, specifying the business proposed to be transacted at

it, and signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf shall be delivered to every member, or sent by post to the usual place of residence of such member, so as to be available to them at least three clear days before the meeting. Failure to service the notice on any member shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by members pursuant of clause 3.1.3 the notice shall be signed by those members and no business shall be transacted at the meeting other than that specified in the notice.

3.2.3 A member desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 12 clear days before the meeting. The request shall state whether the item of business is proposed to be transacted in the presence of the public, subject to approval of the Board of Directors as per 3.17.1, and shall include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.4 If the Board of Directors is required to meet in public, details of the meetings will be displayed throughout the Trust including on the Trust's website at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

3.3 Agenda and Supporting Papers

3.3.1 Agendas and supporting papers will be sent to members 5 days before the meeting, save in emergency. Failure to serve such a notice on more than three members will invalidate the meeting.

3.4 Setting the Agenda

3.4.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5 Petitions

3.5.1 Where a petition has been received by the Trust the Chairman of the Board of Directors shall include the petition as an item for the agenda of the next Board of Directors meeting.

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3.6 Notice of Motion

3.6.1 Subject to the provision of Standing Orders 3.8 'Motions: Procedure at and during a meeting' and 3.8.7 'Motions to rescind a resolution', a member of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.6.2 The notice shall be delivered at least 12 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.7 Emergency Motions

3.7.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.8 'Motions: Procedure at and during a meeting', a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.8 Motions: Procedure at and during a Meeting

3.8.1 **Who may Propose**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

3.8.2 **Contents of Motions**

The Chairman may exclude from the debate at his discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

a) the reception of a report;
b) consideration of any item of business before the Board of Directors;

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c) the accuracy of minutes;
d) that the Board of Directors proceed to next business;
e) that the Board of Directors adjourn; and
f) that the question be now put.

3.8.3 **Amendments to Motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.8.4 **Rights of Reply to Motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.8.5 **Withdrawing a Motion**

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

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3.8.6 **Motions Once Under Debate**

When a motion is under debate, no motion may be moved other than:

a) an amendment to the motion;
b) the adjournment of the discussion, or the meeting;
c) that the meeting proceed to the next business;
d) that the question should be now put;
e) the appointment of an 'ad hoc' committee to deal with a specific item of business; and
f) that a member/director be not further heard.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8.7 **Motion to Rescind a Resolution**

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the member who gives it and also the signature of 4 other Board of Directors members. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any member other than the Chairman to propose a motion to the same effect within 6 months, however, the Chairman may do so if he/she considers it appropriate and in the interests of the Trust.

This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.8.8 **Written Resolutions**

The Chair may propose a Board of Directors' written resolution by giving written notice to the Secretary specifying the business to be carried out. A Board of Directors' written resolution is proposed by giving written notice of the proposed resolution to each director. Notice by post, delivery in person, fax or email shall constitute written notice.

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Notice of a proposed Board of Directors' written resolution must dictate:

a) the proposed resolution;
b) how to signify agreement to the resolution; and
c) the date by which it is proposed that the Board of Directors should adopt it.

A written resolution shall lapse if not adopted by the 28th day of circulation. The resolution is deemed to have been passed when the required majority have signified their agreement to it.

3.9 Chairman of Meeting

3.9.1 At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Vice-Chairman, if there is one and they are present, shall preside.

3.9.2 If the Chairman and Vice-Chairman are absent such member (who is not also an officer of the Trust) as the members present shall choose shall preside.

3.10 Chairman's Ruling

3.10.1 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members appointed, (including at least one Non-Executive Director and one Executive Director) are present.

3.11.2 An officer in attendance for an Executive Director but without formal acting up status will not count towards the quorum.

3.11.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not

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available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.11.4 The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Non-Executive Nomination and Remuneration Committee).

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

3.12.3 If at least one-third of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

3.12.4 If a member so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

3.12.7 A manager attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the

voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.12.8 For the voting rules relating to joint members see Standing Order 2.6.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by NHS Improvement/Monitor or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (including at least one member who is an Executive Director of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board of Directors' minutes.

3.13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Board of Directors.

3.13.4 No formal business may be transacted while Standing Orders are suspended.

3.13.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall be amended only if:

a) a notice of motion under Standing Order 3.6 has been given;
b) upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
c) no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment;
d) two thirds of the Board of Directors members are present at the meeting where the variation or

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amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment; and

e) the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

3.15.1 The names of the Chairman and Directors present at the meeting shall be recorded in the minutes. The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link in accordance with the Constitution. Participation where agreed shall be deemed to constitute presence in person at the meeting.

3.16 Minutes

3.16.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.16.3 Minutes shall be circulated in accordance with members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.17 Frequency

The Trust shall hold meetings of the Board of Directors at least nine times in each calendar year.

3.18 Admission of Public and Press

3.18.1 Meetings of the Board of Directors shall not be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting. The Chair may exclude any member of the public from an open meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

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3.18.2 Arrangements for the public to attend the Board of Directors meeting shall not be construed as allowing them any right to speak at the meeting. However, at the discretion of the Chair and with the agreement of Directors, individuals, including representatives of the professional bodies and those with an expert point of view, may be invited to contribute views on specific matters.

3.18.3 Observers invited to attend meetings of the Board of Directors shall receive agenda papers and may be permitted to speak by invitation from the Chair, but not to propose motions nor to vote.

3.18.4 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.19 Annual Members Meeting

The Trust will publicise and hold an annual members meeting, in accordance with the terms of the Constitution.

4. APPOINTMENT OF COMMITTEES, SUB–COMMITTEES AND WORKING PARTIES

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Independent Regulator, the Trust Board of Directors may appoint committees of the Trust.

4.1.2 The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.1.3 A Committee may, subject to such directions as may be given by the Independent Regulator or the Trust, appoint Sub-Committees or Working Parties consisting wholly or partly of members of the Committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Committee (whether or not they include Directors of the Trust).

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4.2 Joint Committees

4.2.1 Joint committees may be appointed by the Trust by joining together with one or more Commissioners, or other providers consisting of, wholly or partly of the Chairman and members of the Trust or other bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term "Chairman" is to be read as a reference to the Chairman of the committee as the context permits, and the term "member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

4.4 Terms of Reference

4.4.1 Every committee, sub-committee and working party shall have such terms of reference, powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation or direction issued by NHS Improvement/Monitor. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where committees are authorised to establish sub-committees they may not delegate power to the sub-committee unless expressly authorised by the Board of Directors.

4.6 Approval of Appointments to Committees

4.6.1 The Board of Directors shall approve the appointments to each of the committees, sub-committees and working parties which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee, sub-committee or working party the terms of such appointment shall be within the

powers of the Board of Directors as defined by NHS Improvement/Monitor. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory Functions

4.7.1 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the relevant authority.

4.8 Standing Committees established by the Board of Directors

The standing committees, sub-committees, joint-committees, groups and boards established by the Board of Directors are:

4.8.1 **Audit Committee**

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and NHS Improvement/Monitor's Code of Governance, an Audit Committee will be established and constituted to make recommendations and provide the Board of Directors with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference have been approved by the Board of Directors and are reviewed on a periodic basis.

The Code of Governance recommends all members of the Audit Committee to be independent.

4.8.2 **Non-Executive Nominations and Remuneration Committee**

In line with the requirements of the NHS Code of Governance, a Committee responsible for Executive nominations and remuneration will be established and constituted. This Committee has been constituted under the name of Non-Executive Nominations and Remuneration Committee.

In line with the Code of Governance recommendations the Committee is comprised of the Chairman and Non-Executive

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Directors. The Chief Executive shall also be appointed a member of the Committee.

The purpose of the Committee will be to advise and make recommendations to the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

(a) all aspects of salary (including any performance-related elements/bonuses);
(b) provisions for other benefits, including pensions and cars; and
(c) arrangements for termination of employment and other contractual terms.

4.8.3 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board of Directors has established a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.9 and Standing Financial Instructions 17.

4.8.4 **Quality Assurance Committee**

The Committee will monitor, review and report on the quality (safest care, effectiveness of care, best experience) of clinical and social care services provided by the Trust. This will include review of i) the systems in place to ensure the delivery of safe, high quality, person-centred care ii) quality indicators flagged as of concern through escalation reporting or as requested by the Trust Board iii) progress in implementing action plans to address shortcomings in the quality of services, should they be identified.

4.8.5 **Finance, Performance and Digital Committee**

The Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy, major investment decisions, information management and technology functions.

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4.8.6 **People Committee**

The Committee shall undertake on behalf of the Trust Board objective monitoring, reviewing and reporting on matters relating to the Trust workforce, including delivery of the Trust's People Plan. This will include review of and assurance on the recruitment, retention, training, employee health and wellbeing, learning and development, employment engagement, OD, leadership and workforce development, workforce spend, workforce plans, employee culture, diversity and inclusion of the organisation.

4.8.7 **Torbay Pharmaceuticals (TP) Management Board**

The Trust has delegated management responsibility of the Torbay Pharmaceuticals operational delivery to the TP Management Board. The Board shall comprise a Non-Executive Chairman and include at least one Executive and one Non-Executive Director of the Trust.

The TP Board recommends the strategy of the TP to the Board of Directors. The TP Board approves the objectives and plans of the TP and oversees and monitors the performance of TP business.

The TP Board reports to the Board of Directors on all matters associated with the above.

4.8.8 **Other Committees**

The Board of Directors may also establish such other committees as required to discharge the Trust's responsibilities.

4.8.9 **Committee for Appointing/Removing the Chief Executive as Director**

As laid down in the Trust's Constitution, it is for the Non-Executive Directors to appoint (subject to the approval of the Council of Governors) or remove the Chief Executive (and accounting officer).

4.8.10 **Committee for Appointing/Removing Executive Directors other than the Chief Executive**

As laid down in the Trust's Constitution, a Committee, whose members shall be the Chairman, the Non-Executive Directors and

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the Chief Executive of the Trust, will appoint or remove the Executive Directors of the Trust, other than the Chief Executive.

4.8.11 **Confidentiality**

A member (or an attendee) of a Committee shall not disclose a matter dealt with by, or brought before, a Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter. A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has concluded, if that Board or Committee shall resolve that it is confidential.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to such directions as may be given by the Independent Regulator, the Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions:

a) by a committee, sub-committee or working party;
b) appointed by virtue of Standing Order 4.1 or 4.2 or by an officer of the Trust;

in each case subject to such restrictions and conditions as the Trust thinks fit or as the Independent Regulator may direct.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 2.8) may in emergency be exercised by the Chief Executive and the Chairman. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

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5.3 Delegation to Committees

5.3.1 The Board of Directors may agree to the delegation of powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Independent Regulator. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their delegated powers shall be approved by the Board of Directors.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee or joint-committee with power to act shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the Scheme of Delegation which shall be the subject of consideration and approval by the Board of Directors as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer to provide information and advise the Board of Directors in accordance with statutory or the Independent Regulator requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board of Directors as set out in the Reservation of Powers to the Board of Directors and Delegation of Powers document shall have effect as if incorporated in these Standing Orders.

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5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

6.1.1 The Board of Directors will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board of Directors minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

a) the NHS England Guidance 'Managing Conflicts of Interest in the NHS' and the Trust's Policy for Trust staff;
b) the staff Disciplinary and Appeals Procedures adopted by the Trust;

both of which shall have effect as if incorporated in these Standing Orders.

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6.3 Standing Financial Instructions

6.3.1 Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific Guidance

6.4.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care:

a) UK Caldicott Guardian Council Manual 2017;
b) Human Rights Act 1998;
c) Freedom of Information Act 2000; and
d) Managing Conflicts of Interest in the NHS Guidance (1 June 2017).

7. DUTIES AND OBLIGATIONS OF BOARD OF DIRECTORS MEMBERS /DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and Applicability to Board of Directors Members

The Constitution requires Board of Directors members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing members of the Board of Directors shall declare such interests. Any Board Directors appointed subsequently shall do so on appointment.

7.1.2 Interests which are Relevant and Material

Interests which shall be regarded as "relevant and material" are:

a) employment directorships and remuneration, including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

b) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
d) a position of trust in a charity or voluntary organisation in the field of health and social care;
e) any connection with a voluntary or other organisation contracting for NHS services;
f) research funding/grants that may be received by an individual or their department;
g) interests in pooled funds that are under separate management;
h) gifts, hospitality and/or sponsorship;
i) related party disclosure(s); and
j) any application to a special interest group campaigning on health or social care issues.

Any member of the Board of Directors who is aware, or becomes aware, that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board Director shall declare their interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Board Directors have any doubt about the relevance of an interest, this shall be discussed with the Chairman of the Trust or with the Trust's Company Secretary. The Company Secretary retains guidance in respect of interests and disclosures.

Latest IFRS and NHS England guidance should also be considered in accessing the relevance of an interest.

7.1.4 Recording of Interests in Board of Directors Minutes

At the time Board Directors members' interests are declared; they shall be recorded in the Board of Directors minutes.

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Any changes in interests shall be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publicity of Declared Interests in Annual Report

Board Directors directorships of companies likely or possibly seeking to do business with the NHS shall be published in the Board of Directors' Annual Report and the Trust website. The information shall be kept up to date for inclusion on the Trust website and in succeeding annual reports.

7.1.6 Conflicts of Interest which Arise During the Course of a Meeting

During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision (see overlap with Standing Order 7.3).

There is no requirement in the Code of Accountability for the interests of Board Directors' spouses or partners to be declared. However, Standing Order 7, which is based on the regulations, requires that the interest of directors' spouses, if living together, in contracts shall be declared. The interests of Board Directors spouses and cohabiting partners shall also be regarded as relevant and therefore if a conflict of interest is established it should be declared. In addition if it becomes evident during the course of a Board of Directors meeting that a Director has a conflict of interest due to their spouse or cohabiting partner interests, the director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive Directors and Non-Executive Directors, as defined in Standing Order 7.1.2.

7.2.2 These details will be kept up to date and will include an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

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7.2.3 The Register will be available to the public in accordance with NHSE Guidance 'Managing Conflicts of Interest in the NHS' June 2017.

7.2.4 The Audit Committee shall monitor and review compliance with the NHSE Guidance for declaring interests in the NHS.

7.3 Disability of Chairman and Directors in Proceedings on Account of Pecuniary Interest

7.3.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
(ii) "contract" shall include any proposed contract or other course of dealing;
(iii) "Pecuniary interest"
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) they, or a nominee of them, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same; or
b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to Pecuniary interests
A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member; or
b) any interest that they or any person connected with them may have in the contract is so remote or insignificant

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that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract; or

c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £25,000 in nominal value or five per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2.

7.3.2 Exclusion in Proceedings of the Board of Directors

Subject to the following provisions of this Standing Order if the Chairman or a Board Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Board of Directors may exclude the Chairman or a Board Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

Any remuneration, compensation or allowance payable to the Chairman or a Director by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances)or any subsequent related Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not they are also a Director of the Trust) as it applies to a Director of the Trust.

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7.4 Standards Of Business Conduct Policy

7.4.1 Trust Policy and National Guidance

All Trust staff and directors must comply with the Trust's Managing Conflicts of Interest Policy and the guidance 'Managing Conflicts of Interest in the NHS' issued by NHS England.

7.4.2 Interest of Officers in Contracts

Any officer or employee of the Trust who is aware, or becomes aware, that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable.

An officer shall also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

The Trust and national guidance requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4.3 Canvassing of, and Recommendations by, Directors in relation to Appointments

Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

An officer must also declare to the Chief Executive any other employment or business or other relationship of theirs or a cohabiting spouse/partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

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A Board Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.4.4 Relatives of Directors or Officers

Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

The Chairman and every director and officer of the Trust shall disclose to the Chief Executive any relationship between them and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Director of OD and Workforce any such disclosure made. In the case of a declaration by the Chief Executive that should be made to the Chairman and reported to the Director of OD and Workforce.

On appointment, directors prior to acceptance of an appointment shall disclose to the Board of Directors whether they are related to any other director or holder of any office in the Trust.

Where the relationship to a member of the Trust is disclosed, the Standing Order headed `Disability of Chairman and directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

7.4.5 Compliance with the Fit and Proper Person Regulations The

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all Trusts to ensure that all Executive and Non-Executive Director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Person Regulations (FPPR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board

meetings. The regulations stipulate that Trusts must not appoint or have in place an Executive Director or Non-Executive Director unless they meet the standards set out in the Regulations. The guidance issued by the Care Quality Commission (CQC) in January 2018 places ultimate responsibility on the Chairman to discharge the requirements of the FPPR. The Chairman must assure themselves that new applicants and existing post holders meet the fitness checks and do not meet any of the unfit criteria. Responsibility also falls on the Chairman to decide whether an investigation is necessary and, at the end of the investigation, to consider whether the director in question remains fit and proper. The Chairman will be notified by the CQC of any non-compliance with the FPPR, and holds responsibility for making any decisions regarding action that needs to be taken.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

8.1.1 The Common Seal of the Trust shall be kept by the Chief Executive in a secure place.

8.2 Sealing of Documents

8.2.1 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating directorate/division).

8.2.3 Where a document needs to be sealed, the seal shall be affixed in the presence of the above officers and shall be attested by them (see Appendix B).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the

document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

8.4 Signature of Documents

8.4.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or Chief Finance Officer, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

9 MISCELLANEOUS (see overlap with SFI No. 10.3)

9.1 Joint Finance Arrangements

9.1.1 The Board of Directors may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977 or subsequent acts. The Board of Directors may confirm contracts to transfer money from the NHS to the voluntary sector or the health or social care related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999 or subsequent acts and shall comply with

procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

See overlap with Standing Financial Instruction No. 10.3.

9.2 Integrated Care Organisation

Under the Risk Share Agreement with South Devon and Torbay Clinical Commissioning Group and Torbay Council the parties agree to pool budgets in Torbay and South Devon NHS Foundation Trust for the delivery of Health and Adult Social Care to the population those bodies represent. The management of that pooling is set out in the Risk Share Agreement signed by all the parties.

9.3 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of, and understand, their responsibilities within SO's and SFI's. Updated copies shall be issued to all staff in email format designated by the Chief Executive.

9.4 Documents having the standing of SO's

SFI's and the Scheme of Delegation shall have effect as if incorporated in to the SO's.

9.5 Review of Standing Orders

SO's and all documents having effect as if incorporated in to the SO's, shall be reviewed every two years by the Audit Committee on behalf of the Board of Directors.

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APPENDIX A

Standards of Business Conduct

The following documents must be read in conjunction with the Trust's Managing Conflicts of Interests in the NHS Policy published on the Trust's intranet.

The seven principles of public life (Nolan principles) apply to anyone who works as a public officer, and includes all people appointed to work in health, education, social and care services. Accordingly, all staff employed by the Trust (or its subsidiaries as they apply) are expected to adhere to the Nolan Principles. They are:

1. **Selflessness:** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

2. **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

3. **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for awards or benefits, holders of public office should make choices on merit.

4. **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. **Leadership:** Holders of public office should promote and support these principles by leadership and example.

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Part A

Bribery Act 2010 - summary of main provisions

Further guidance can be found at
http://www.justice.gov.uk/guidance/making-and-reviewing-the-law/bribery.htm
or search for 'Fraud and Bribery Prevention Policy' on the Trust intranet.

The Trust has a zero tolerance policy to bribery and all policies and procedures will be reviewed to ensure they reflect the requirements of this policy and the detail of the Bribery Act 2010.

The Chief Finance Officer has overall responsibility for ensuring the Trust has adequate procedures for compliance with the Bribery Act 2010.

Specifically the Chief Finance Officer in relation to procurement, sponsorship and hospitality and the Director of Workforce and Organisational Development in relation to expenses.

Acceptance of gifts by way of Inducements or rewards

1. Under the Bribery Act 2010, it is an offence for employees corruptly to accept or offer any gifts or consideration as an inducement reward for:

   a) doing, or refraining from doing, anything in their official capacity; or
   b) showing favour or disfavour to any person in their official capacity.

2. Under the Bribery Act 2010, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

TP managers are in a more exposed position than most other NHS staff as not only do they have the power to award contracts, they are also engaged in winning new customers and increasing sales. The TP Management Board should ensure training is provided for staff that could be put in a position where judgement around this Act is necessary and as part of that should cover the following:

1. Any casual gifts which the TP may wish to offer its customers should first be approved by the TP Board.
2. Such hospitality could be provided at the discretion of the Managing Director and only with the prior approval of the Chairman of the Torbay Pharmaceuticals Management Board. On occasion, this type of

expenditure may, for acceptable business reasons, exceed that initially authorised. In such circumstances, the Managing Director must seek the retrospective approval of the Chairman of the Torbay Pharmaceuticals Management Board. Such hospitality should be reasonable and proportionate.

TP staff should be mindful of the continued need for the prudent use of public funds. The Association of the British Pharmaceutical Industry (ABPI) Code of Practice, clause 22, which relates to meetings, hospitality and sponsorship, states that:
'*The cost of a meal (including drinks) provided by way of subsistence must not exceed £75 per person, excluding VAT and gratuities.*'

Section 10.4 of the Standing Financial Instructions refers.

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Part B

Standards of Conduct (this section should be read in conjunction with the Trust's Managing Conflicts of Interest in the NHS Policy.

Introduction

1. These guidelines are intended to be helpful to all NHS employers and their employees

Responsibility of NHS employers

2. NHS employers are responsible for ensuring that these guidelines and those under the Bribery Act 2010 are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff

3. It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS Staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business

4. It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an employee to corruptly accept or offer any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts (see PART A).

   Staff will need to be aware that a breach of the provisions of these Acts renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS

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Principles of conduct in the NHS

5. NHS staff are expected to:

   a. ensure that the interest of patients remains paramount at all times;
   b. be impartial and honest in the conduct of their official business;
   c. use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

6. It is also the responsibility of staff to ensure that they do **not:**

   a. abuse their official position for personal gain or to benefit their family or friends;
   b. seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles

Casual gifts

7. Casual gifts offered by contractors or others, e.g. at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Such gifts should nevertheless be politely but firmly declined. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality

8. Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

   TP staff should refer to Part A above and section 10.4 of the Standing Financial Instructions.

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Declaration of interests

10. NHS employers need to be aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.

11. All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12. One particular area of potential conflict of interest that may directly affect patients is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

13. In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above; also the more detailed guidance to staff contained in Part D and Part F.

14. NHS employers should:

    a) ensure that staff are aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts;
    b) keep registers of all such interests and making them available for inspection by the public;
    c) develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

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Preferential treatment in private transactions

15. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts

16. All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS), reproduced at PART E.

Favouritism in awarding contracts

17. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

    a) no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
    b) each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

18. NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

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Warnings to potential contractors

19. NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

20. NHS employees are advised not to engage in outside employment that may conflict with their NHS work, or be detrimental to it. They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

Private practice

21. Consultants (and associate specialists) employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the guidance 'Managing Conflicts of Interest in the NHS'. Consultants who have signed new contracts with Trusts will be subject to the terms applying to private practice in those contracts.

22. Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in paragraph 20 above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties under "Category 2" (paragraph 37 of the TCS of Hospital Medical and Dental staff), e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Foundation Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative

23. NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work

commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 2004 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 2004 or subsequent acts. To achieve this, NHS employers should build appropriate specifications and provisions into the contractual arrangements that they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

24. With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is affected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25. In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under their contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences

26. Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.

27. On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

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Commercial Sponsorship of posts ("linked deals")

28. Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for an employing authority. NHS employers should not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the authority. Where such sponsorship is accepted, monitoring arrangements should be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

    Under no circumstances should employees agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"

29. Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS are concerned, and whether or not is prompted by the expectation of personal gain (see paragraphs 16 18 above and Part E).

30. However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

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Part C

Action checklist for NHS managers in relation to the Trust's Policy: Managing Conflicts of Interests in the NHS

YOU must:

a) ensure that all staff are aware of this guidance;
b) develop a local policy and implement it;
c) show no favoritism in awarding contracts to businesses run by employees, ex-employees or their friends or relatives);
d) include a warning against corruption in all invitations to tender;
e) consider requests from staff for permission to undertake additional outside employment;
f) apply the terms concerning doctors' engagements in private practice;
g) receive rewards or royalties in respect of work carried out by employees in the course of their NHS work, and ensure that such employees receive due rewards;
h) similarly ensure receipt of rewards for collaborative work with manufacturers, and pass on to participating employees;
i) ensure that acceptance of commercial sponsorship will not influence or jeopardize purchasing decisions;
j) refuse "linked deals" whereby sponsorship of staff posts is linked to the purchase of particular products or supply from particular sources;
k) avoid excessive secrecy and abuse of the term "commercial in confidence".

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Part D

Short guide for staff on Standards of business conduct for NHS staff

Reference document: NHS England Guidance 'Managing Conflicts of Interest in the NHS'

Do:

a) make sure you understand the NHS England guidelines on managing conflicts of interests , and consult your line managers if you are not sure;
b) make sure you are not in a position where your private interests and NHS duties may conflict;
c) declare to your employer any relevant interests. If in doubt, ask yourself:

   i. am I, or might I be, in a position where I (or my friends/family) could gain from the connection between my private interests and my employment?
   ii. do I have access to information which could influence purchasing decisions?
   iii. could my outside interest be in any way detrimental to the NHS or to patients' interests?
   iv. do I have any other reason to think I may be risking a conflict of interest?

   If still unsure - **Declare it!**;

d) adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services;
e) seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (Special guidance applies to doctors);
f) obtain your employer's permission before accepting any commercial sponsorship .

Do not:

a) accept any gifts, inducements or inappropriate hospitality;
b) abuse your-past or present official position to obtain preferential rates for private deals);
c) unfairly advantage one competitor over another or show favoritisms in awarding contracts ;
d) misuse or make available official "commercial in confidence" information.

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Part E

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Professional Code of Ethics

An introduction to our code of ethics

1. Members of our Institute undertake to work to exceed the expectations of the following Code and will regard the Code as the basis of best conduct in the Purchasing and Supply profession.
2. Members should seek the commitment of their employer to the Code and seek to achieve widespread acceptance of it amongst their fellow employees.
3. Members should raise any matter of concern of an ethical nature with their immediate supervisor or another senior colleague if appropriate, irrespective of whether it is explicitly addressed in the Code.

Key principles

4. Members are required to uphold the Code and to seek commitment to it by all parties they engage with in their professional practice; enhance the standing of the Purchasing and Supply profession; and, always act professionally and selflessly by:

    - Maintaining the highest possible standard of integrity in all business relationships, both inside and outside the organisations where they work by:
      not accepting inducements or gifts (other than declared gifts of nominal value which have been sanctioned by their employer;
      not allowing offers of hospitality or those with vested interests to influence, or be perceived to influence, their business decisions;
      declaring any personal interest that might affect, or be seen by others to affect, any impartiality in decision making.
    - Rejecting any business practice which might reasonably be deemed improper and never using their authority for personal gain.
    - Enhancing the proficiency and stature of the profession by acquiring and maintaining current technical knowledge and the highest standards of ethical behaviour.
    - Fostering the highest standards of professional competence amongst those for whom they are responsible.
    - Optimising the responsible use of resources which they have influence over for the benefit to their employing organisation.

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- Complying both with the letter and the spirit of:
  - The law of the country in which they practise and in countries where there is no relevant law in practice.
  - Following Institute guidance on professional practice.
  - Fulfilling agreed contractual obligations.

5. Members should never allow themselves to be deflected from these principles.

Guidance

6. In applying these principles, members should follow the guidance set out below:

   - Declaration of interest - any personal interest which may affect or be seen by others to affect a member's impartiality in any matter relevant to his or her duties should be declared.
   - Confidentiality and accuracy of information - the confidentiality of information received in the course of duty should be respected and should never be used for personal gain. Information given in the course of duty should be honest and clear.
   - Competition - the nature and length of contracts and business relationships with suppliers can vary according to circumstances. These should always be constructed to ensure deliverables and benefits. Arrangements which might in the long term prevent the effective operation of fair competition should be avoided.
   - Business gifts - business gifts, other than items of very small intrinsic value such as business diaries or calendars, should not be accepted.
   - Hospitality - the recipient should not allow him or herself to be influenced or be perceived by others to have been influenced in making a business decision as a consequence of accepting hospitality. The frequency and scale of hospitality accepted should be managed openly and with care and should not be greater than the member's employer is able to reciprocate.

Decisions and advice

7. When it is not easy to decide between what is and is not acceptable, advice should be sought from the member's supervisor, another senior colleague or the Institute as appropriate. Advice on any aspect of the Code is available from the Institute.

This Code was approved by the Council of CIPS on 10 September 2013

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Part F

Guidance on managing conflicts in the NHS

On 9 February 2017, NHS England issued new guidance on managing conflicts of interests in the NHS. This guidance set out:

- Introduced common principles and rules for managing conflicts of interest;
- Provided simple advice to staff and organisations about what to do in common situations; and
- Supported good judgement about how interests should be approached and managed.

This guidance came in to force on 1 June 2017 and is applicable, amongst others, to NHS Foundation Trusts. This guidance supersedes and extinguishes the Standards of Business Conduct for NHS Staff (HSG(93) 5).

The Trust has adopted the model policy issued by NHS England, which includes the content of the guidance. The Trust policy can be found on the intranet for staff and the Trust website. To help staff members understand what they need to do and how the guidance applies to them, NHS England have published some questions and answers for provider managers, clinical staff and medical staff – all of which are available on the staff intranet.

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APPENDIX B

Sealing of Documents

1. Form of Attestation

An appropriate form of attestation for documents is "The Common Seal Torbay and South Devon NHS Foundation Trust was unto here affixed in the presence of..... "

2. **Use of the Seal**

2.1 The seal is a corporate signature. It may be interchangeable with the words "for and on behalf of the Trust" for documents of minor importance and/or value. The use of the seal indicates that the document is important and/or valuable. No common law exists regarding any financial limits which require a seal; however, a seal must be used in the conveyancing of land.

2.2 If the Trust gives an undertaking, the sealing of a document imposes an obligation. A signature does not reduce the obligation, but a seal reaffirms the obligation expressed within the document. In cases where the Trust is uncertain, a signature could be offered 'for and on behalf of the Trust' and if this is refused, the seal can be used.

2.3 The Trust or its officers may decide that a document shall be sealed, within the provisions of the NHS Acts.

2.4 The following documents should be sealed:

a) Land Conveyances;
b) Shares or bond transfers and sales.

2.5 The following documents may be sealed:

a) Legal agreements and licences;
b) When a seal is requested by the other party.

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Report to the Trust Board of Directors			
Report title: Board Assurance Framework and Corporate Risk Register			Meeting date: 25th October 2023
Report appendix:	Appendix 1: Board Assurance Framework Appendix 2: Corporate Risk Register		
Report sponsor:	Director of Corporate Governance and Trust Secretary		
Report author:	Corporate Governance Manager		
Report provenance:	Reviewed by Board Sub-Committees – People Committee, Quality Assurance Committee, Finance, Performance and Digital Committee, Building a Brighter Future Committee and Risk Group.		
Description/Purpose of the report and key issues for consideration/decision:	Please find enclosed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) for the Board's review. 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. The Board has delegated detailed review of a number of risks to Board Sub-Committees. During October 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. 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. Since the last meeting amendments have been made to Objectives 2, 3 and 7. A new objective, Objective 11 in relation to Equality, Diversity and Inclusion has been added, as agreed at the Board of Directors meeting in September.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to: (i) Note the Board Assurance Framework; and (ii) Note the Corporate Risk Register.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The report supports the Board in identifying those risks that could affect the Trust's aim of supporting the people of Torbay and South Devon to live well, and to take account to ensure those risks are mitigated against and managed.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources		

	The report enables the Board to ensure any risks that affect delivery of the Triple Aim are identified and mitigated against.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	N/A
External standards affected by this report and associated risks	Care Quality Commission NHS England licence and regulations National policy, guidance

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BOARD ASSURANCE FRAMEWORK 2023/24

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

Our People AT THEIR BEST

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	Updates made to the resource uplift around the areas of risk for the Trust, assigned to some of the key risks on the corporate register.
3	Financial Sustainability	CFO	25	15	General updates, in particular to reflect MTFP and impact of Industrial Action
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	General Updates
8	Transformation and Partnerships	DTP	16	9	
9	Integrated Care System	DTP	16	8	
10	Green Plan/Environmental, Social and Governance	CFO	12	6	
11	Equality, Diversity and Inclusion	CPO	16	12	New objective added to BAF

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

Consequence (Impact) / Likelihood	1 Minimal	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 - Almost Certain	5	10	15	20	6, 4, 2, 3
4 - Likely	4	8	10, 12	8, 9, 16, 1, 11	20, 2
3 - Possible	3	6	9	12	5, 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:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Oct 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: • Awaiting outcome of CQC Inspection in June/July 2023 which will determine scope of internal QOI program • Demand and Capacity modelling presents a significant gap in terms of TSDFT meeting levels of activity at pace and scale • New operational structure • Capacity challenges in operational and medical leadership • Continued Pressure on the emergency pathway • Clinical Governance Framework new and not mature • Informatics / Quality metric a significant challenge • NoF 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 • Workforce Challenges in terms of attrition, sickness and morale – to be further impacted by Industrial action over quarters 3 and 4 of 2022/23 • There remains a Moderate risk to the quality of patient care. The likelihood of the risk materialising remains as Likely (x).
Likelihood	4	4	4	4	4	4	
Consequence	4	4	4	4	*3*	4	
Risk Score	16	16	16	16	12	16	

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 NOF 4 exit criteria is a significant challenge.	1.1B	Setting out medium to long term plan for reconfiguration of services to meet risk/demand 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 : 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 c) Delayed ambulance handovers 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 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 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 a) Continuous review of NICE recommendations and communication of new/changing requirements by the Quality Effectiveness Team. b) Monitoring framework of concerns and feedback from patients and service users 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 Maturing	1.1C	System /ICS around plans to address inequalities in access and treatment
1.3A	Strengthen accountability and improvement through new Care Group Structure	1.1C	Central government control restricting ability to prioritise local needs
1.3A	Need to strengthen and Mature Governance and oversight through new divisional structure 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 • System approach to service reviews through PASP • Governance and oversight in place • SRO in place – TSDFT CEO
1.1A	Ensure delivery against NOF 4 Exit Criteria in terms of quality and improved performance	COO	April 2024 (to review)	• Improvement Targets agree- set out in SOF 4 • Detailed plans developed with support of recovery • 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 • Mortality review /process in place to understand recent increase in Mortality – linking with ICS • 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 following the June/July 2023 Inspection	CNO	October 2023	• Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and NOF 4 criteria • Ward Accreditation Framework in place and strengthened in 2022/23 • Internal audit around compliance against 2020 CQC Action Plan completed in Autumn 2021 • Ongoing Quality and safety walkabout in place • 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 • 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	CNO	April 2023	• Revised Structure in place but inconsistent • Development Program to be designed and implemented • AWS to deliver development program
1.3A	Strengthening of quality oversight and assurance at service at Care group level through new operating model	CNO	July 2023	• New operating model in place- Launch 1st April • 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 • KPIS Reviewed for QI Priorities • 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.	CNO	April 2023	• Patient Engagement Strategy launched August 2022 • 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 at work where our people feel safe, healthy and supported.				
Internally Driven: ✓ Externally Driven:						
Responsible Executive:		Chief People Officer	**Committee:**	People Committee	**Last Updated:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**Aug 24**	**Oct 22**	
Likelihood	4	4	5	5	4	4	NOF4 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. Our cultural dashboard data (sickness, rolling sickness, long term sickness, age profile, holiday taken, overtime hours, bank and agency spend, and turnover) highlights areas that 6 out of 9 are in red RAG 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 CQC letter following Well-led inspection highlighted the level of work to do regarding EDI. 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.
Consequence	4	4	4	4	4	4	
Risk Score	16	16	20	20	16	16	

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 September 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	2.4C	Continued poor leadership and management behaviours will exasperate an already fragile workforce and reinforce that their concerns are not

			expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in leadership.		listened to, further compounding fragility challenges.
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. 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 24	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 NOF4 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.	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 excerbate workforce fatigue and wellbeing decline, and not aid recovery.
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	2. Skillset of managers to enforce policy or to investigate is in need of improvement		

	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	CPO	Mar 24	Agency use monitored through Nursing & Midwifery Workforce Transformation Council from June 2023 and reported into Recovery group.
2.10A	1&2 New TSD Leadership and Management framework and resources will be launched from September 2023 that focus on a leadership responsibility of all to include listen and act	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. Complete - launched at the end of September 2023. A process of rolling out and embedding commences from now.
2.10A & 2.11 A&C	3. Key risk areas identified across the People Directorate including People Hub capacity, EDI, Workforce analysis; 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 Directorate.	CPO	**Dec 23**	Interim People Hub manager in post until Dec 23 and uplift to resources now in place June 23. Additional resource uplift secured in key risk areas of ER Team, EDI. Medical Workforce and Workforce Data analysis.

Risk Summary					
BAF Reference:	**3. FINANCIAL SUSTAINABILITY**				
Objective:	To achieve financial sustainability and deliver the ICS five 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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Oct 22**	There is a risk that the Trust fails to deliver sufficient improvement to achieve the five-year system recovery plan (including productivity). 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	5	4	5	
Consequence	5	5	5	5	4	5	
Risk Score	25	25	25	25	16	25	

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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 4 exit requirements
3.8A	Financial impact of ongoing industrial action	3.8B	Robust operational planning to minimise financial impact where possible	3.8C	Deterioration in financial performance and failure to deliver NOF 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.
3.5A	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:**
3.5A/3.7A	Efficiency plan for 2023/24	CFO	Ongoing	In delivery, significant gap with developing mitigations.
3.2A	Systems improvements (Prevero, Tableau, Genesis)	DOpFin	Oct 23	Underway with risk of slippage
3.2A	Ensure full reconciliation of workforce and financial data	DOpFin	Oct 23	Still work in progress – now depends on additional input within Workforce Information Team
3.2A/3.5A/3.7A	Develop MTFP model (5 year plan) in line with revised ICS principles and methodology (then informing BBF business cases)	DOpFin	Oct 23	First stage (baseline) model complete – Next steps to develop further the operational plan that supports the MTFP model – to include CIP identification workforce/activity/performance - and 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	Dec 23	Operational structure introduced and in the process of being embedded. Proforma accountability agreements developing through COO
3.4A	SFI refresh taking account of (8)	DOpFin	Dec 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:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sep 23**	**2030**	**Oct 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	5	
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	10	25	

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 NOF4 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 NOF4 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 NOF4 exit needs Damage to the Trust's reputation both as a provider of care and an employer Potential for litigation due to claims from employees on the basis that basic, fit for purpose working accommodation is not being provided 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. 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 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 NOF4 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 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) • TIF bid for day surgery theatres (target completion late 2023) • New RT/CT scanners – in progress • 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:**	October 2023

BAF Risk Scoring

Current Position	Jan 23	Mar 23	Jul 23	Sept 23	Target Position April 24	Year on Year Oct 22	Rationale for Risk Level
Likelihood	5	4	4	5	3	4	Consequence: Performance Risk - Failure to meet professional standards or statutory requirements. 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.
Consequence	4	4	4	3	4	4	
Risk Score	20	16	16	15	12	20	

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. Work programme of transformation improvement team in respect of urgent care recovery plan. UEC Group improvement programmes overseen by Trust Recovery Board UEC funding agreed with ICS. Weekly Tier 1 meetings with ICS and NHSE	5.1.C	Delays in progressing patient decisions resulting in delays in treating patients both internally and externally
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. Community Transformation Group being established overseen by Trust Recovery Board Agreement on funding arrangement to incentivise market development. Newton Europe Report concluded, and actions being implemented	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. 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. Planned Care Group improvement programmes overseen by Trust Recovery Board.	5.4.C	Failure to deliver on NOF4 exit criteria resulting in reduced organisational control

			Weekly PLT review meetings to progress patient pathway for Cancers and Electives. Tier 1 Regional Support . Regional Mutual Aid including access to Nightingale Hospital Exeter. TIF funding for additional capacity agreed.		
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. 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.
5.7A	Industrial action continues to impact elective and non-elective recovery programmes.	5.7 B	Trust Industrial Action and Patient Safety Committee in place, chaired by COO. Strike specific 'playbook; developed to ensure information and coordination of mitigating actions is developed and managed. Engagement with clinical teams increased to assess and clarify IA impact and resolution to identified areas of concern.	5.7 C	Failure to deliver on NOF4 exit criteria resulting in reduced organisational control. Patients' appointments delayed resulting in poor patient experience and harm.

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.	5.7 A	Externally driven engagement between concerned parties resulting in settlement and end of IA

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	Continued application of improvement methodologies to ensure appropriate decision making and engagement
5.1 A	Job planning analysis agreed using external consultancy Kendell Bluck	COO	Nov 23	
5.5.A	Development of new EPR and data system	DT&P	Jan 25	Funding streams in development
5.7 A	Development of IA specific Trust 'playbook' for management of different IAs	COO	Sept 23	

Risk Summary					
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:**	Building a Brighter Future Committee	**Last Updated:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Oct 22**	Current IT systems and supporting infrastructure will not meet the current of future business need. The current likelihood remains the same and is driven by two reasons; firstly the level of known vulnerability of the PAS / LIMS systems which will cease to be supported from 2024. Secondly, general cyber security vulnerabilities (such as Log4shell) are significant threats to IT systems globally. The recent cyber-attacks against the Ortivis provider used by SWAST has still not been fully resolved and restored and is the second within a calendar year (the other being against Advanced which affected CAHMS and CFHD). 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)
Likelihood	5	5	5	5	5	5	
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	25	25	

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 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. Exceptional ASW report relating to this Process in place to review and respond to national NHS Digital CareCERT notifications 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) 2023/24 capital plan, including external Frontline Digitisation funding 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 Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences Damage to the Trust's reputation e.g. Loss of local services, IG Breach, Financial loss
6.2A	Computer hardware risks 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, and being implemented through 2023	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

			IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical infrastructure areas		the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences 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 EPR solution not being sufficiently flexible to deliver level of clinical transformation required	6.3B	EPR business case OBC approved, with a clear route to national funding Trust has an approved Digital strategy that aligns with the delivery of the Trust Strategy and the ICS digital strategy Regain & Renew/NOF4 Exit transformation priorities being aligned with change/transformation driven by the EPR implementation Clinical pathways being aligned across organisations and further enabled by a robust GIRFT process, facilitating standardisation in a shared EPR The Trust Board has undertaken the NHS Providers Digital Boards Programme and has a NED with a specialist expertise and experience in Digital	6.3C	Inability to maintain 'many systems' approach for both technical (complexity) and financial reasons, leading to limited support for business needs 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	2023/24 capital plan, including external network funding Critical systems identified with clinical and corporate colleagues LIMS procurement underway with assurance regarding the required go-live timescales IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical 'end of life' IT system 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 Increasing change of software licensing to subscription models	6.5B	2023/24 capital plan, including external Frontline Digitisation funding Procurement of an EPR with a high level of functional scope that reduces the number of siloed IT systems underway Procurement/implementation of shared IT systems between organisations 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	2023/24 capital plan, including external Frontline Digitisation funding System approach to data centre provision being formulated Learning from the Guys & St Thomas' critical IT failure and the 'Black Swan' element of risk they identified had been missing from their risk policy	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	2023/24 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 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
6.8A	Torbay Council procurement of replacement to PARIS (Internal Audit review has identified shortcomings in terms of reporting functionality of adult social care data and system is at its end of life)	6.8C	The procurement of a new system and the Trust's awareness of the fragility of the system, as well as oversight by internal audit ensure performance is monitored.	6.8C	The PARIS replacement system will provide a new platform to record adult social care data, however the Trust also uses PARIS for other community functions and it is not clear if the new system will include those functions. In addition, it is not known if Torbay Council will purchase the same system that is used by neighbouring Councils to enable a streamlined approach.
6.9.A	Efficacy of clinical record keeping and undertaking risk assessments at appropriate time frames relies on human based triggers and memory, rather than automated prompts to undertake processes.	6.9B	The procurement of the EPR and the Trust's awareness of the fragility of the system, as well as oversight by internal audit ensure performance is monitored.	6.9C	At times record keeping may not be as efficient and is not automated in line with process.

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
6.3A, 6.8A, 6.9A	National funding dependent on FBC approval 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, 6.5A, 6.6A, 6.7A	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.
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. 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:**	October 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Jan 23	**March 23**	**Jul 23**	**Sept 23**	**May 23**	**Oct 22**	
Likelihood	3	3	3	3	3	3	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	5	
Risk Score	15	15	15	15	15	15	

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	The 'seed' funding for 2023/24 has now been confirmed at a further £1.06m, which is in line with the funding provided for the last 2 years. In addition, the Trust has been able to secure a further £422,000 which will be required to complete the Site Enabling FBC.	7.4.C	The Trust now has the required funding to complete the site enabling FBC, which will enable the business case to be presented to the Trust Board in either April or May 2024.
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 to avoid 'step in' it is essential that the programme is able to benefit from the required clinical and operational support.

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 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. 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: ○ Detailed design for site enabling ○ Integrated assurance strategy for programme ○ Workforce planning	7.1B	External • Lack of assurance in relation to NHP cohort 4 capital funding and timetable at a national level • 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:**
7.1B	Action to address lack of assurance in relation to capital funding and national timetable delay	Director of Transformation & Partnership	Ongoing	Data gathering exercise with the NHP national team is now in its second stage and the latest return was provided to the national team on 5th October. This process will deliver a timetable and resource allocation for the Trust by 31st March 2024.
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	The OBC for the site enabling measures will be presented to Trust Board in September 2023. This business case has now been presented to the NHP for their review. Approval scheduled January 2024.

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	The planning scenarios required by NHP have been shared with the BBF committee.
7.5A	Master Planning – the outcome of the peer review master planning exercise will be presented to the BBF committee	Director of Transformation & Partnerships	October 2023	The initial drafts of the masterplanning work will be presented to the BBF committee in October. A final report will be available in January which will set the direction for the future development of SOC and OBC

Risk Summary					
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:**	Building a Brighter Future Committee	**Last Updated:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**March 24**	**Oct 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. 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. 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. There isn't a unified and single approach to a standardised and co-ordinated programme of change, implemented reliably across the ICS. Basic IT and estate infrastructure is poor and hampers significant levels of transformation at pace
Likelihood	4	4	4	4	3	5	
Consequence	4	4	4	4	3	4	
Risk Score	16	16	16	16	9	20	

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 NOF4 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 Executive		

			Quality Group) oversight of overall programme of change proposed will sit with new BBF Committee TOR – implementation in July 2023.		
1.8A	Culture of Continuous Improvement not embedded into organisation to enable improvement capability across workforce.	1.8B	Oversight of programme to embed continuous improvement methodology, including self-assessment against national NHS Impact standards delivered through Transformation Group and reported to BBF Committee. (October 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. Turnover within team (maternity, retirement and internal promotion) leading to additional recruitment drive October 2023.
1.7A, 1.7B	All transformation portfolios led by Executive leads and delivering against agreed milestone actions with robust monitoring	DTP	Sept 2023	Improvement portfolios with milestones aligned to NOF 4 exit criteria commissioned by Executive Directors and regular monitoring in place via monthly reports to recovery board. Detailed oversight of delivery via UEC Group, Planned Care Group and Community Group all chaired by COO.
1.3A	Capability programme delivery for 23/24	DTP	Mar 2024	Curriculum in place to deliver improvement training at Foundation & Practitioner levels. Induction training now in place for all new staff. Training for clinical cohorts established. Organisational baseline assessment due October 2023 for NHS IMAPCT (national Improvement Board newly established).
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	Business case presented – PAPC required further review, next case to be presented at end of August 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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Oct 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. 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.
Likelihood	4	4	4	4	2	n/a	
Consequence	4	4	4	4	4	n/a	
Risk Score	16	16	16	16	8	n/a	

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:	Chief Finance Officer supported by Workplace Director	**Committee:**	Board	**Last Updated:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**Sept 23**	**Oct 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. This could lead to: 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. Damage to public confidence, statutory non-compliance, regulatory breaches.
Likelihood	n/a	4	4	4	3	n/a	
Consequence	n/a	3	3	3	2	n/a	
Risk Score	n/a	12	12	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 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 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 Reputational damage for the Trust 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 Reputational damage for the Trust 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 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. 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 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 Green champions currently being appointed 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
10.4A	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

Risk Summary						
BAF Reference:	**11. EQUALITY, DIVERSITY AND INCLUSION**					
Objective:	To have an increased focus on equality, diversity and inclusion to address the increase in bullying and harassment across the organisation					
Internally Driven: ✓ Externally Driven:						
Responsible Executive:	Chief People Officer	**Committee:**	People Committee	**Last Updated:**	October 2023	

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**Sept 25**	**Oct 22**	We will not have fair and equitable behaviours, processes, policies and procedures. There will be a poor experience of staff with protected characteristics, which will lead to poor patient experience and outcomes. A failure to address inequalities across all protected characteristics- demonstrated by overrepresentation of minority ethnic groups and disabled groups in formal ER processes. We will not attract nor retain, nor develop a diverse leadership cadre.
Likelihood	n/a	n/a	n/a	4	3	n/a	
Consequence	n/a	n/a	n/a	4	4	n/a	
Risk Score	n/a	n/a	n/a	16	12	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
11.1A	Lack of inclusive leadership or management framework, development or key accountability expectations, results in direct and indirect discrimination.	11.1B	Our People Promise priorities and our Inclusion and culture plan are aligned with the High Impact areas of the NHS EDI improvement plan. A co-created leadership framework (Include, Listen, Act) and a management training programme have been designed. Now approved at Board , the roll out plan has commenced. Our compassionate leadership framework will be used to identify leadership expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in inclusive leadership.	11.1C	We will experience high rates of ER cases and Employment Tribunals, high sickness levels and poor wellbeing, where a lack of psychological safety to raise concerns exists. The risk to the Trust reputation will be high, impacting on our ability to recruit and retain a diverse workforce.
11.2A	Unclear career pathways and talent management impacts on retention and wellbeing of workforce	11.2B	People Promise work will design clear career pathways and a trust wide talent management plan. Career conversations and career coaching are offered to everyone.	11.2C	Impact on recruitment and retention of a diverse workforce whereby managers' recruitment practices are not fair and equitable, nor are development and progression opportunities.
11.3A	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 long term conditions (Staff Survey Results 2022), suggests that the workplace culture in TSD is not	11.3B	Just and Learning Culture survey, aligned to Patient Safety, helped to identify where in the Trust there are particular issues in psychological safety. New Leadership framework, along with priority 3 (inclusive culture plan) has inclusivity at its heart. To	11.3C	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, wellbeing and patient care.

	inclusive. This was highlighted in the recent CQC letter following the Well led inspection.		focus on culture (including Just and Learning culture roll out- inc policies), inclusion, civility, safety to speak up and challenge inappropriate behaviour. A commitment to embedding and mainstreaming D&I through leadership, learning and development. Formal reports are completed, published with robust action plans, aligned to our inclusive culture plan/people promise priority including WRES, WDES, EDS-2, Gender pay gap review.		

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
11.1A	EDI objectives and development is absent from Trust Board development	11.1A; 11.3A	No current system (ICS) EDI lead, so there is a lack of direction in terms of collaboration, and sharing of best practice across organisations.
11.3A	EDI element of induction for all staff is virtual, and is reported to have a less significant impact on behaviours and values.		
11.3A	The current mandatory training is not fit for purpose, nor aligned with our people promise and is not having the desired impact on some of the behaviours we are experiencing		
11.2A, 11.3A	Onboarding and induction for our internationally recruited staff		
11.3A	We have no identified, trusted individuals advocating for EDI across the organisation, within teams		
11.3A	Our networks are not complete- we have missing voices among marginalised groups, specifically our disabled colleagues and those with LTCs.		

Action Log: (actions identified to achieve target risk score)

No. Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
11.1A	EDI Trust Board development sessions to be identified.	CPO	March 24	EDI Trust Board development sessions have been identified and diarised aligned to the compassionate leadership framework development.
11.2A	The new induction that is in place to onboard our internationally recruited staff will include a more comprehensive EDI/cultural element – to create a more robust sense of belonging and empower them to speak up	CNO	Dec 23	EDI now attends the induction to discuss culture/culture shock elements which is developing in line with feedback. EDI lead working with coordination of the induction to ensure a more robust follow up. Culture ambassador training has been offered to our nurse managers.
11.3A	To re-introduce face to face Trust induction, including a face to face EDI/Culture element.	CPO	Jan 24	
11.3A	To identify, train and roll out Inclusion Champions trust wide to advocates for EDI, Inclusion and belonging	CPO	March 24	

11.3A	Developing our staff networks and chairs to gain confidence in sharing their lived experience and inform decision making and improvements with a particular focus on our Disability network.	CPO	March 24	
11.3A	To create an enhanced mandatory EDI training module and a 12 month campaign to consolidate the training.	CPO	Jan 24	The inclusion module has been created. The creation of the enhanced module will begin in Nov 23.

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Torbay and South Devon NHS
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	Specialty	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)	Action Point/Plans relating to Risk 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.
1083	01/01/2016	Corporate Level Risk	Estates	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Bvoe)	Financial Risk		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. Effects: A. Failure of aged plant and deteriorating building fabric, resulting in unplanned cancellation of clinical services. B. Potential impact on ability to meet RTT and other contractual clinical standards. C. Increased risk of harm to staff, patients or members of the public from failing infrastructure. D. Increased estate maintenance costs (revenue and capital) and risk of financial penalties due to clinical breaches. Linked to Risks: DRM ID No 2353 - Cellular Pathology Portacabin No Longer Fit for Purpose. (16) DRM ID No 2542 - Potential Failure of Theatres DSU 3 & Ophthalmology Ventilation Units. (16) DRM ID No 2720 - Leaking Roofs Across Torbay Hospital Site (20) DRM ID No 2718 - Inability To Expand Clinical Services Due To Lack Of Space.(15) DRM ID No 2719 - Chilled Water System Failure (16) DRM ID No 2836 - Telemetry System Upgrade. (Used for looking for causes of collapses & side effects of medication.) (16) DRM ID 3192 - Issues With Inadequate Lighting Sources at Torbay and Newton Abbot for Max Fac Outpatients (15) DRM ID 3193 - Clinic Environment For Max Fac Patients In Alternative Accommodation (15) DRM ID 3473 (20) Mortuary Capacity Consistently Exceeding 100% Standard Capacity DRM ID 2429 Ward Kitchens Environment in Acute and Community Settings in Need of Updating - 26 locations identified.(16) DRM ID 3621 External Wall Tiles on Tower Block becoming loose with potential to detach from their fixings and fall from height (20) DRM ID 2718 Inability to expand clinical services due to lack of space (15) DRM ID 2878 Increased fire risk in the Torbay Hospital tower block due to sustained failure to meet statutory standards (15)	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. 2. Increased financial contingency built into capital programme to respond to unplanned critical estates failures. 3. Increased maintenance for key areas. 4. Business continuity plans in place to respond to potential loss of infrastructure. 5. Robust planned preventative maintenance regime in place. 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. 7. Statutory Estates Roles and Responsibilities appointed and tracked monthly. 8. Annual review of mandatory and statutory systems compliance by externally appointed Authorising Engineer(s). 9. Board has approved annual capital programme based on actively considered risks versus maintaining a cash balance. 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. 2. Equipment and plant continues to fail and due to age, cannot always be repaired. 3. Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities. 4. Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity.	31/10/2023	Catastrophic	Almost Certain	25	[31/07/2023 12:09:44 Paul Hayman] No change - review in October 2023. [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. [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. 5-10 Year Capital plan will also help to address Backlog elements. AMU completed and scoping work for TIF and Endoscopy units underway to provide 4,500 additional cases per year - (Ophthalmology). Consideration of allocation of funds for patient / colleagues experience and safety. To be reviewed end March 2023.	Catastrophic	Possible	15						
1159	19/09/2012	Corporate Level Risk	All Departments (Risk Only)	Gary Hotine	Adé Jones	Director of Transformation and Partnership (Adé Jones)	Information and Communications Technology Risk		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. Effects: A. Failure of key IT infrastructure and IT systems resulting in impact on service delivery. 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. C. Inability to meet future statutory or regulatory requirements around reporting. D. Possible impact on clinical systems impacting patients /service users. 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. F. Inability to achieve the Government's requirement (2023) of 100% having or implementing EPRs by 2026. Note: Our plans are predicated on an on-going capital investment plan to ensure optimum performance of service. Linked to Risks: 1168 - National Programme for IT HSCIC. 1174 - Increasingly Software Companies Are Changing Their Licensing. 2019 - Symphony IT System for Emergency Dept not Reliably Sending Safeguarding Referrals to Allocated Drive. 2696 - WinPath V5 Incompatibility Risk. 2781 - Maternity Information System 2830 - Computer Hardware Risks (Replaces 1173 & 2280) 2831 - Computer Infrastructure Risks (Replaces 1164, 2275, 1166 & 1185) 2838 - Potential Failure to Meet Cyber Security and Information Governance Standards Set by NHS Digital. (Replaces 158 & 1161) 2864 - Failure of the Trust Dell Storage Platform During Routine Patching Maintenance. 3309- Patient Admin System Becomes Unsupported 2161 - Viewpoint System End of Product Life 3460 - Compromise or Failure of Cloud Hosted IT Services or Systems	Catastrophic	Almost Certain	25	1. ICT Strategy with supporting policies and procedures e.g. Business Continuity Plans. 2. Well-developed IM&T service, linked strategically with ICS digital delivery strategy/plans. 3. Upgrade current key systems to mitigate effect. 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. 5. Investment planning to maintain and develop infrastructure capacity. 6. Continued IM&T Strategic investment. Risk assessment based on need and prioritised accordingly. 7. Continual review of emerging technology and adoption where suitable and funding permits. 8. Minimising critical failure. 9. Management of failure. 10. Internal audit reviews. 11. Actions following Information Commissioners Office visit (Sept 2015 & follow ups in 2018 and 2022). 12. Retention of individuals or contractors with requisite skills and experience to provide tactical software enhancements to plug gaps in legacy systems. 13. PC deployment programme. 14. Replacement data network. 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, national approval expected July 2023. FBC approval expected 2023/24.	Ctrl's 5.6.7.13, 14 & 15 total investment requirements outstrip the Trust's capital funding capacity to be allocated to reduce risks (2022 example - inability to fund the £1.4m EUD scheme).	01/03/2024	Catastrophic	Almost Certain	25	[05/10/2023 12:46:21 Joshua Langdon] Desktop, Server & Network environment all currently in warranty and support with no impending (12 month) risks of warranty. [14/06/2023 09:05:21 Gary Hotine] Updated Actions [09/05/2023 10:19:44 Gary Hotine] Risk scoring reviewed	Major	Possible	12	Support the activities described in the Trust's Digital Strategy regarding the priority action to procure an EPR	Gary Hotine	21/02/2024			[14/06/2023 09:04:44 Gary Hotine] OBC with national team for approval
3309	03/11/2021	Corporate Level Risk	IT Operations	Gary Hotine	Adé Jones	...rtnership (Adé Jones)	...ions Technology Risk		Other not listed	Patient Admin System Becomes Unsupported	Cause: The PAS is obsolete and support will cease. 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. 2. HIS resourcing business case approval, or an agreed System solution required to ensure capacity exists to achieve the PAS replacement from April 2022.	1/10/1/2024	Catastrophic	Almost Certain	25	[14/07/2023 10:48:39 Gary Hotine] No Change - EPR Procurement starting in July 23 and Preferred Bidder expected in November 24. This will enable the score to be reassessed [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.	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.	Adé Jones	01/02/2024			[26/09/2022 18:31:33 Gary Hotine] Taken to Execs and FPDC twice but no funding solution available

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						Director of Transformation and Pa	Information and Communica														[26/09/2022 18:33:34 Gary Hotine] Updated to reflect progress on formal support extension.				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 [08/03/2023 10:48:17 Gary Hotine] Supplier maintains the agreed position. [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. [18/11/2022 14:32:16 Gary Hotine] Met with the new InterSystems account manager, James Ormonde. Stressed the need for ISS to provide air cover to Dedalus on Cache support so that Dedalus can provide the assurances the Trust requires. He agreed to progress this with Dedalus. [03/10/2022 08:24:38 Gary Hotine] Email over the weekend from InterSystems as follows: On 1 Oct 2022, at 13:17, Luke Tapper <Luke.Tapper@intersystems.com> wrote: Hi Gary,
2996	01/02/2021	Corporate Level Risk	Finance	Tian Ze Hao	Tian Ze Hao	Chief Finance Officer (Mark Brice)	Financial Risk		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. Effect: 1. Certain Failure to deliver 2023/24 deficit financial plan 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 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 Linked to Risks: 2997 Overspend On Variable Staffing - 2021/22 Budget Levels. 2402 Increasing Costs Of High Value Drugs & Devices 3274 Failure to Identify and Deliver CIP	Catastrophic	Almost Certain	25	1. Tightened internal financial governance and the adoption of the Budget Spending and Investment Protocols adopting a budget envelope approach 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 NHSE/ 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. 4. Deep dives undertaken at Finance, Performance and Digital Committee. 5. Programme office and management function established, monitoring and reporting delivery of schemes. 6. Regular updates provided to the system Finance Working Group and system financial recovery board, progression of ICS wide savings initiatives. 7. Exec-led performance monitoring of delivery systems. 8. CIP targets established in detail at service level, with Executive sponsors and management leads identified for schemes. 9. External support from Deloitte on drivers of deficit in 2023/24 commissioned by ICB 10. CQC Use of Resources inspection approach 11. Benchmark data such as NCCI, Model Hospital, PLICS 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 2. Interruptions to meetings cycles (routine governance) due to operational pressures. 3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing	30/11/2023	Catastrophic	Almost Certain	25	[23/08/2023 14:08:07 Tian Ze Hao] Risk still remain the same driven by unidentified / under-delivery of CIP schemes and the increasing cost pressure in Adult Social Care. This is not just for 23/24, for the medium term we are developing a joint understanding with ICB on interventions required. [26/05/2023 09:29:27 Dave Stacey] Updated DS May 2023 [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.	Catastrophic	Likely	20							
1070	29/05/2014	Corporate Level Risk	Emergency Department (ED)	Joann Hall	Lisa Houlihan	Chief Operating Officer	Performance Risk		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. Effect: Failure of the 95% standard, poor patient experience and possible adverse clinical outcomes as patients not cared for in the correct environment. Linked to other ED CLR: 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. 2. New medical "O" drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier. 3. Escalation policy in place. 4. 3 x daily control meetings with real-time information and appropriate management responses. 5. Ward discharge coordinators have daily meetings to review ward discharges. 6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED. 7. "See & Treat" trial in 2017 was successful and is now used during periods of escalation. 8. JET Team now fully operational to provide support for early discharge. 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. 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. 11. Increased robustness of internal ED escalation. 12. Improvements to RAR space to enable additional capacity when unit is full. 13. Changes to corridor traffic to prevent thoroughfare use. 14. Creation of an Medical Receiving Unit in DSU as part of the COVID response. 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. 2. Patient flow out of the ED and other assessment spaces (MRU/SRU)	30/10/2023	Catastrophic	Likely	20	[29/03/2023 11:27:49 Amanda Anders (Risk Officer)] Title changed by COO [22/11/2022 17:30:40 Melody Andrews] Risk reviewed and no change at present [10/06/2022 10:36:11 James Merrell] Risk reviewed and no changes at present.	Catastrophic	Unlikely	10	To support improvements an urgent care board has been established to monitor the workstreams affecting flow and process issues across ED, medicine , frailty , bed management and discharge processes. Each workstream holds a specific action plan for improvement measures which is monitored weekly with oversight weekly at the urgent care board .	Joann Hall	29/03/2024				[16/07/2023 13:37:34 Joann Hall] Minutes and action log available in shared teams drive
3486	14/11/2022	Corporate Level Risk	All Departments (Risk Only)	Liz Davenport	Liz Davenport	CEO (Liz Davenport)	Financial Risk		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. Effect: Insufficient financial resources to deliver adequate health and social care services to the population we serve. Lack of skilled workforce to deliver future predicted demand and transformation. Strategic partners do not deliver priority strategic programmes of work Linked risks: 3484: Failure of acute provider collaborative to deliver on acute sustainability plan programme 3485: Failure of ICS operating framework to support collaboration in line with health and social care policy requirements	Catastrophic	Likely	20	1. Chair,CEO and Executive engagement with ICS Committees and decision making groups 3.Development of ICS governance arrangements to include ICB, ICP Local Care Partnerships and Provider Collaboratives 4. ICS Board appointments, Executive Team and Programme Director capacity 5. Provider Collaboratives- Acute, MHLDN and plans for Primary Care and Community 6.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 7.TSDFT CEO leads the Acute Provider Collaborative and Chair, DCEO and CMO also members 8.Influence at Strategic/Clinical networks: ICS Executive, Finance Working Group and HRD Executive Forum 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. 10. System Recovery Board. 11. Trust internal governance.	Internal 1.Lack of robust planning arrangements 2.Operational capacity and governance External 3.Financial Plan/Devon System Health and Care Strategy 4.Lack of of engagement from partnership providers to impact positively on pace of change 5.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. 6.Implications of revised governance arrangements on FT governance and decision making	11/12/2023	Catastrophic	Likely	20	[22/05/2023 10:04:29 Sophie Byrne] The following controls were added to the risk: - System Recovery Board. - Trust internal governance. [14/02/2023 11:21:26 Amanda Anders (Risk Officer)] Discussed at risk group and approved onto the CRR [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	04/12/2023				
																									System Operating Plan	Liz Davenport	04/12/2023				
																									Trust Governance Process - Recovery Board	Liz Davenport	04/12/2023				
																									Leadership Capacity and Capability	Michelle Weaswood	04/12/2023				
																									Regain and Renew (SOF4 Exit plan)	Ariel Jones	04/12/2023				

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2416	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rooth	Emma Rooth	Deputy Chief Executive Officer	Financial Risk		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. Effect: Failure to meet financial targets. Significant financial, reputational and people risk.	Catastrophic	Almost Certain	25	1. Annual budgeting process. 2. Five year plan with long term aims. 3. Monthly financial review and presentation at Torbay Pharmaceuticals Board meeting. 4. ERP implemented. 5. Standard costing model applied to all products in business. 6. Horizon scanning of new dosage forms, technologies and changes in clinical practice. 7. Development planning including licensing and product development. 8. Project and Resource planning.	1. Ability of TP to make one-off investments (access to capital). 2. Post Brexit/Covid-19 impacts - inflation on labour and materials. 3. External investment. The entire plan was predicted on basis that significant external financing would be available. 4. Governance. Failure to separate from the Trust presents barriers in acquiring the skills and knowledge required to deliver on the plan. 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. [05/09/2022 14:06:22 Kim Hodder] Actions 10283 and 10287 closed. Action 10282 progress updated. Addition of Action 18722. [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 [06/03/2020 12:03:39 Kim Hodder] TP Strategy Plan refreshed. Ongoing discussions with Trust.
																									Gain clarity on strategic direction of TP	Emma Rooth	31/10/2023			
1815	05/08/2014	Corporate Level Risk	Cancer Waits Team	Alex Atkins	Ria McCoy	Chief Operating Officer	Performance Risk		Site Non-Specific	Non Compliance With The National Cancer Waiting Time Targets.	Causes: Insufficient capacity to manage demand across some cancer pathways. A. LGI capacity for outpatient clinics, CT colon and colonoscopy. Unable to deliver timed cancer pathways through diagnostics to enable achievement of the 62 day pathway consistently. B. Urology capacity for outpatients and DSU diagnostics reduced. Dedicated outpatient space to deliver TP biopsies at Paignton Hospital in outpatient setting (Prostate pathway) building work completion awaited. Significant delays to TP biopsies. c. Consultant vacancies in Dermatology and Urology. Reliant on Locum cover. D. Insufficient capacity in diagnostics - CT, CTC, MRI and colonoscopy to achieve the timed pathways for Lung, Urology, LGI and Gynae. Effects: A. Clinical risk to patients with delays diagnosis and delayed access to treatments. B. Increasing number of patients being reported as potential harm caused by delays to treatment. C. Failing the CWT targets for 14 days referral to first seen. Increasing 62 day referral to treatment breaches. D. Failing to achieve 62 day referral to treatment target across 8 cancer sites E. Failing to achieve 28 day referral to diagnosis standard across many specialities F. Additional work ongoing to escalate, complete breach analysis and recovery plans. G. Poor Trust reputation and increased scrutiny from regulators.	Major	Almost Certain	20	2. Fortnightly Cancer Task and Recovery meetings with Senior Management and Devon ICB 3. Site specific escalation lists on Infoflex for operational managers to access 4. Cancer Clinical Leads meetings to share risks and concerns across the ICO 5. Regular reporting to Planned Care Board to escalate risks and concerns 6. Cancer patients are always prioritised when capacity reduced 7. Weekly PTL meetings set up with at risk cancer sites to escalate potential breaches and discuss concerns 8. Cancer Alliance fixed term A&C roles recruited to in order to try and recover PTL performance and data	1. Lack of Consultants to recruit to vacancies. (Substantive and locums.) 2. Clinical space and equipment to provide additional capacity 3. Lack of nursing staff in some areas to support additional clinical activity. 4. Significant increase in demand on services post COVID 5. Fully established CWT team against budget under resourced due to increase in demand and unable to track PTLs daily and escalation where appropriate	27/10/2023	Major	Almost Certain	20	[06/09/2023 16:18:27 Jacqui Robinson] Review with AAJR - current performance for August positive bassing 28 and 31 day standards. 62 day best performance since September 2020. However, 62 backlog starting to rise, main impact in Gynaecology due to staffing absences (secretaries, consultants and nurses). New CWT v12 released from 1st October 2023 - performance impact expected to be minimal. Joint consultant and junior doctors strikes in September and October expected to impact on cancer performance. [12/07/2023 11:58:37 Jacqui Robinson] Torbay have now moved out of Tier 1 for cancer performance however this needs to be sustained. Whilst the over 62-day backlog has reduced the Trust are still failing the 14d, 31d and 62 day standards and remains a significant organisational risk. To be reviewed in 3 months. [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.	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	21/09/2023			[24/07/2023 11:18:07 Jacqui Robinson] Trust is currently 25th highest performing trust across the country, maintaining position at present and achieved 28 day standard for the past 5 months. Work ongoing to improve performance within Gynae, Colorectal and Urology who are our main areas of concern and all failing 28 day target. Improvements still to be made in order to improve 2ww, 31d and 62d targets across numerous sites. Diagnostic delays, in particular radiology, having the biggest impact. [21/06/2023 08:38:41 Jacqui Robinson] Trust no longer in Tier 1 as great improvements made in 62 day performance and PTL. 28 day national target has been achieved each month from February. Improvements still to be made in 2ww and 31 day
																					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 Pine	08/07/2023			[24/07/2023 08:02:23 Emma Brooks] 24/7/23 - TP biopsy waiting times now within target and works currently underway at Paignton Hospital to create a procedure room, due for completion August 23 [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. [05/05/2022 09:43:09 Jake Gibbons] Reassigned to Ali El-Eleimi from Neal Foster
																					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 [10/03/2022 14:43:51 Alex Atkins] Completed for Breast, Derm, Urology and LGI. [25/02/2022 08:41:14 Alex Atkins] 25/02/2022 - Action plan template created and started to be populated [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 (Risk Only)	Sandie Heyworth	Darren Westcott	Chief Operating Officer	Performance Risk		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. Effect: Poor patient experience and quality of care, reputational impact for the Trust Linked to Risks: DRM ID No 2307 - Oncology Outpatient Clinic Issues. DRM ID No 2036 - Endocrine Outpatients - Increase on Demand with Limited Consultant Time. DRM ID No 3574 - Waiting Times and Clinical Capacity in Speech and Language Therapy	Major	Almost Certain	20	1. Performance reporting and action plans with support of the Performance team, via Risk and Assurance weekly meeting 2. Waiting list management process, weekly PTL meetings 3. Operational teams identifying capacity and maximising all available sessions, also utilising insourcing companies and outsourcing where able. ICB supporting and involved with oversight 4. Support from other specialities creating sense of team working, ie UGI team supporting colleagues within Colorectal to reduce cancer backlog. Greater system working across the region with Urology 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. 2. Insufficient training grades resulting in consultants having to action down. 3. Inability to outsource complex patients - patients are deconditioned and higher ASA levels reducing ability to transfer care 4. Funding considerations not supporting recruitment of consultant surgeons. 5. National shortage of urology consultants. 6. Unable to source anaesthetic locums. 7. Heat and humidity issues within theatres - ongoing concerns across both seasons (summer and winter)	31/08/2023	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 [17/01/2023 13:02:31 Amanda Anders (Risk Officer)] Risk re-written by Nicky Croxon to ensure it is completely up to date. [27/09/2021 09:40:03 Neal Foster] Best week 29th Sept allowing Ella to be use for DSU recovery and ortho patients. Response for OT limited at AfC and LNC rates Approval sought for insourcing of urology diagnostics Sessions at Tiverton and Ottery picked up for TP biopsies. MSH transfers OP/DCIP continue as do 5 endoscopy sessions per week	Moderate	Likely	12						
1697	07/11/2016	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Financial Risk		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. Effect: Difficulties in delivering on corporate objectives and national targets. Increase in temporary workforce usage including agency leading to budget overspends. Linked to Risks: DRM 3209 CT Staffing Level (Workforce Risk) DRM 3183 Inadequate Staffing Levels Creating Risk to Patient Safety and Potential to Impede Patient Flow (Workforce Risk) DRM ID No 1432 - Histopathologist Staffing Levels Causing Operational Risk. DRM ID No 1566 - Radiography Staffing Levels. DRM ID No 1603 - Breast Radiology Team reduced availability - Vacancies in Main Radiology. DRM ID No 1830 - Cancer Services Vacancy for Breast and Colo-rectal Clinical Oncology. DRM ID No 1931 - Lack of Resource to Assist with IT Projects & Service Redesign. DRM ID No 2066 - Vulnerability of Medical Take Due to Increases in Last 10 Years. DRM ID No 2528 - Reduced Staffing Numbers Resulting in	Major	Almost Certain	20	1. Recruitment updates are reported to Board bi-monthly as part of Workforce Report. 2. Medical Recruitment is being looked at as part of the Trust's Recruitment Strategy working groups. 3. Performance Report identifies where compliance with RTT/ED/STC impacted by workforce shortage. 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. 5. E-Rostering system in place for nursing staff. 6. Restricted use of agency staff. 7. Use of bank staff wherever possible. 8. Additional support from current staff. 9. Risk discussed at Local level with escalation process for risks. 10. 15+ being linked to this risk. 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. 12. STP Workforce and Clinical network development. 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. Ctrl 2. Link between requirement to train additional staff and sufficient capacity to deliver placements for students and other trainees. 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. [28/02/2023 15:34:01 Sarah Blacoe] emailed manager regarding update [16/02/2023 10:42:23 Sarah Blacoe] emailed manager regarding update	Major	Possible	12						
2412	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rooth	Emma Rooth	Chief Finance Officer (Mark Blow)	Financial Risk		Torbay Pharmaceuticals	Insufficient Access to Capital.(TP)	Cause: TP could be requested to reduce its capex budget in order to support the Trusts CDEL. 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. 2. Reviewed at TP Board meetings. 3. Meetings with Trust FD and TP Chairman. 4. Raised at Trust Board Meetings for assurance.	1. Potential for change in financial requirements of the Trust/NHSE. 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. [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 [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						

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Torbay and South Devon NHS
NHS Foundation Trust

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	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.
3536	14/03/2023	Corporate Level Risk	Human Resources	Darran Armitage	Michelle Westwood	Chief Peoples Officer	Operational Risk		HOS, Torbay Hospital Regents House	Pressure in the People Hub due to a Combination of Increase in Demand on Services and Personnel Churn (Workforce Risk)	Cause: There is considerable pressure in the People Hub due to a combination of increase in demand on services and personnel churn (change of People Hub Manager and the long term sick of one full time member of People Hub and the Associate Dir of People Ops). Effect: There is a risk of reduced output and productivity from the People Hub, with the inability to deliver the Just Culture change in all People policies, to support the growing number of ETs and to support the Org Change throughout the Trust.	Major	Almost Certain	20	1.Appointment of an Interim People Hub Service Manager has been made (6month appointment). 2.Additional resourcing for the People Hub has been approved and recruitment activity is underway. 3.Ongoing sickness absence management reviews are taking place to address LTS of staff (Although there is an unlikelihood of immediate return to work - therefore additional resource demands need consideration throughout May-July) . 4.Temporary resource support is also in place to address some of the work demands but funding for this expires end of June. 5.Training for JLC commences in May to enable work to be undertaken on changes to people polices, and organisation change demands from June onwards. 6. To support Org Restructure, role/requirement of BP and People Hub to be reviewed so scope, number and capacity is set to best meet the organisation.	1.Lack of funding to increase WTE to alleviate pressure 2.Lack of system wide support available 3.Lack of triage and prioritisation of Trust wide projects that impact on People Hub	25/04/2024	Major	Almost Certain	20	[08/08/2023 13:54:19 Amanda Anders (Risk Officer)] Risk approved onto the CRR at risk group. [18/07/2023 08:52:02 Sarah Blacoe] Interim People Hub Service Manager continues to develop knowledge and understanding of working within the Trust/NHS and this is enhancing support to the team. Band 6 vacancy now filled and resulting band 5 vacancy out to advert, Associate Director of People (Ops) has returned to work on a phased basis and is providing support and guidance. [09/05/2023 11:24:29 Amanda Anders (Risk Officer)] Discussed at risk group- members couldn't agree the score and want the scoring matrix to be reviewed. Additional meetings will be set to re-score against new matrix	Major	Possible	12						
3546	19/03/2023	Corporate Level Risk	CFHD Safeguarding	Val Watkins	Cheryl Vidall	Chief Nurse (Deborah Kelly)	Reputational Risk		CFHD, Castle Court	Insufficient Staffing Resources to Meet Increased Demand for Safeguarding Services and MASH Enquiries (Workforce Risk)	Cause: Increase in demand for specialist safeguarding nursing including MASH enquiries. Effect: There is potentially both a Patient Safety risk and Reputational risk from within the MASH service as CFHD safeguarding nurses are unable to manage daily workload, resulting in many cases each day timing out and staff then being unable to access.	Major	Almost Certain	20	1) Good communication with multiagency colleagues to inform them of cases not reviewed - managing expectations. 2) End-to-end mapping of MASH to identify bottle-necks, gaps and demand 3) Staff being rotated through MASH service to reduce risk of burn-out 4) Business case developed to evidence need for additional resource 5) Recent recruitment into B7 Safeguarding nurse role	1) Insufficient staffing levels to manage daily workload in MASH due to current high demand, staff are working long (unpaid) hours to cover / complete most urgent cases. 2) Many cases are becoming 'timed out' and not getting a health review 3) Risk of significant health needs not being included in MASH review if Safeguarding team are unable to get to review case within 24hr window. This 'missing information' could potentially influence decisions made for the child at risk 4) Long term sickness of WTE staff member further impacting on ability to deliver a safe and complete service 5) One member of staff due to reduce working hours	03/11/2023	Major	Almost Certain	20	[10/10/2023 11:38:22 Amanda Anders (Risk Officer)] This risk was discussed in Risk Group and added to the Corporate Risk Register. [04/10/2023 12:33:10 Cheryl Vidall] Risk score reviewed and remains at 20 as we currently continue to have daily amber MASH cases not getting a health review of risks. The initial risk rating is scored by a social worker, who then alerts Health in MASH that a health enquiry (searching all health record sources in Devon) relating to a child needs to be made. There has been a rapid turnover of Social Workers recently, resulting in someone quite inexperienced making the initial assessment and missing the nuanced risks presented on the MASH enquiry forms. Consequently, assurance cannot be offered that all ambers cases are correctly amber rated, as health in MASH has quite frequently increased the risk from amber to red once the health records have been reviewed. This presents a daily potential risk of inaccurate initial RAG rating and therefore the MASH could miss some children whose health information may increase their risk factors from amber to red. Most red cases trigger a strategy meeting where multiagency safeguarding needs are reviewed and action planned. This consequence is currently scored as a 4	Major	Rare	4	Develop new team member to be able to work independently to address MASH staffing shortfall between service demands and service capacity. This will be a 6 month learning curve, with risk starting to reduce over coming months as more cases in MASH will be able to be researched and actioned.	Cheryl Vidall	03/04/2024			[04/10/2023 12:30:49 Cheryl Vidall] Induction underway with ongoing developmental needs being met in first 6 months in new role.
3547	05/04/2023	Corporate Level Risk	Human Resources	Sarah Lehmann	Michelle Westwood	Chief Operating Officer	Reputational Risk		Site Non-Specific	Upwards Trend in Equality, Diversity and Inclusion (EDI) Related Investigations (Workforce Risk)	Cause: 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. Effect: This may lead to an increasing level of staff dissatisfaction, impacting on retention, absence and sickness, as well as a growing trend in reason for Employment Tribunal that will pose financial and reputational issues for TSD.	Major	Almost Certain	20	1. EDI training is mandatory for all 2. People Policy clear that bullying and harassment will not be tolerated and will be investigated fully	1. EDI training is not part of induction 2. Skillset of managers to enforce policy or to investigate is in need of improvement 3. Capacity of People Hub team is stretched against backdrop of current caseload, captured in Risk 3536	25/08/2023	Major	Almost Certain	20	[08/08/2023 13:49:37 Amanda Anders (Risk Officer)] Discussed at risk group to add to the CRR [27/06/2023 15:41:05 Sarah Blacoe] The overarching delivery plan is part of our People promise programme plans- and the detail is being developed, by a series of task and finish groups, with the aim of having sufficient products and development opportunities ready by the launch date. [23/06/2023 14:15:47 Sarah Blacoe] Just culture survey ended 9 June. Data being analysed to identify themes, trends, hotspot areas and action plans to be put in place and will form part of wider culture development plan. Findings and plans to be presented at July PSIRF expert advisory group meeting.	Major	Possible	12	A Just and Learning Culture staff survey will be launched in Apr 23 that will enable an understanding of whether there is a holistic issue in the Trust or whether there are teams that can receive focused EDI and cultural development. Data from the survey will be triangulated with data from People Survey, and People MI relating to grievances, absence and turnover, and patient safety, to ensure that targeted interventions tackle the wellbeing and culture of staff.	Christine Elworthy	25/08/2023			[23/06/2023 14:15:28 Sarah Blacoe] Just culture survey ended 9 June. Data being analysed to identify themes, trends, hotspot areas and action plans to be put in place and will form part of wider culture development plan. Findings and plans to be presented at July PSIRF expert advisory group meeting.
1603	09/07/2018	Corporate Level Risk	Breast Care	Sandie Heyworth	Derren Westacott	Chief Operating Officer	Performance Risk		Site Non-Specific	Delayed diagnosis for Breast Cancer - Capacity Constraints	Cause: 1. Insufficient Radiology capacity to meet demand of service 2. Increase in 2WW referrals 3. 4th Breast Radiologist has left - have appointed replacement but gap until September Effect: 1. The whole Breast Service at risk of falling over without adequate Breast Radiology support and cannot provide a diagnostic service 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. 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. 4. Breast screening film reading and assessment breaches. Linked to Risk: 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. 2. Every radiological appointment, if patients cancel, is backfilled with either a symptomatic or screening patient where possible. 3.Advanced Practice Radiographer now trained and providing capacity in clinic 4. Additional reader now completed training 5. Additional sessions requested with Radiologists 6. Liaison with Radiology Ops Mgr for priority to be given to Breast if possible when timetables being planned 7. Breast radiology support via additional paid sessions for visiting consultants	1. Referrals are unpredictable 2. The Radiologists may not want to / be able to do additional sessions. 3. Current PT Breast Advance Practice Radiographer has retired and returned and could leave at any time giving 3 months' notice. 4. Locum sessions are ad hoc	31/10/2023	Major	Likely	16	[04/08/2023 20:14:30 Sandie Heyworth] Cons Radiographer back at work. Strikes causing issues with capacity, but continue to micromanage the radiology slots [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 [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.	Major	Unlikely	8						
3030	12/03/2021	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Operational Risk		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. 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. 2) A comprehensive package of health and wellbeing interventions, support and guidance with enhanced measures to be offered via management structures and self referral. 3) An analysis of supporting data on staff sickness, overtime, agency spend and unused annual leave to help identify services that may be vulnerable. 4) Trust leadership to use the data provided to control and mandate the pace and pressure of recovery in vulnerable services. 5) Expanding the number of Wellbeing Buddies across the Trust. 6)Continuing with bespoke listening sessions in particular for teams who are part of the system capacity and recovery plans. 7) roll out Apr 2023 of Regain and Renew plan provides clear priorities and permission to innovate/stop work to focus only on priorities. 8)Roll out of Leadership and Management framework Q2 2023 will enhance managers efficiency and improve saisfaction and reduce burnout. 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. 2) Financial envelope available to aid recovery	31/07/2023	Major	Likely	16	[27/06/2023 15:44:13 Sarah Blacoe] [18/06/2021 14:41:56 Sally Simpson] In progress Resources just come back from comms for review [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. [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	Major	Possible	12						

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Torbay and South Devon NHS
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ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	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.
3195	19/05/2021	Corporate Level Risk	PMU Finance	Leon Rudd	Emma Rooth Pharmaceuticals	Emma Rooth Pharmaceuticals (Emma Rooth)	Financial Risk		Torbay Pharmaceuticals	NHS Elective Surgeries Impacting on Sales	Cause: Reduction in NHS elective surgeries due to Covid 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. [17/12/2021 09:20:07 Amanda Anders (Risk Officer)] Risk score increase validated at TP Board [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 Medicine	James Hobbs	Tracey McKenzie	Chief Operating Officer	Clinical Safety Risk		HOS: Torbay Hospital George Earle Ward	Stroke Services (overarching risk)	Cause: 1) Vulnerability of nursing workforce; high number of new nurses including overseas nurses filling what were previously high number of vacancies. 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. 3) Significant pressure within the system including poor flow; challenges to get patients to the right ward within 4 hour target window Effects: 1) & 2) a) Risk of increased clinical incidents; staff not able to get specialist skills in a timely manner. b) Impact on staff health & wellbeing; experienced staff having to support less experienced staff & trying to train staff in an already pressured system c) Difficulty covering specialist nurse & thrombolysis rotas 3) a) Performance on SSNAP - particularly Domain 2 time to & time spent on a stroke unit - poor & continuing to deteriorate b) Reputational risk; Domain 2 is part of CQC performance metrics 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. Linked risks: 1069 Stroke Service Performance Measured in SSNAP - Bed Occupancy and Direct Admission. 3150 Stroke Nursing: Skills & Capabilities (Workforce Risk)	Major	Likely	16	1) Training programmes in place 2) & 3)& 4) ADNPP leading Health & wellbeing work across (SU to support all staff 5) a) stroke improvement plan in place detailing actions & supporting the monitoring of progress b) Regular breach analysis & SSNAP meetings to monitor progress c) Assurance that stroke outliers are seen by Stroke team	Control 3) Ongoing challenge to maintain skills 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. NB: Stroke Risk 1069 remains scored at 16 due to inability to get sustained improvement on Domain 2	31/12/2023	Major	Likely	16	[06/03/2023 16:23:55 Lesley Wade] Risk reviewed. Gap in control updated & action updated. Action owner changed. [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. [01/06/2022 09:36:18 James Hobbs] Risk description and controls updated to reflect that risk 1072 has now been closed. 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 [11/01/2023 08:51:18 Lesley Wade] Ongoing. James Hobbs is refreshing the plan [12/10/2022 13:48:58 Lesley Wade] Ongoing. Actions from Peer review being added to plan
2966	30/11/2020	Corporate Level Risk	Pathology and Laboratories	Anthony Lowe	Ria McCoy	Chief Peoples Officer	Operational Risk		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. Effect: Without a strong staffing model in place across the services there will be numerous issues associated with this risk: A. Potential delay in turnaround times B. Missed RTT targets, including cancer waiting times resulting in fines C. No time allowance for case reviews D. Unable to meet UKAS Standards in Cellular Pathology E. Reliance on locum cover F. Significant service delivery challenge G. Significant recruitment challenge H. Covid testing placing microbiology under pressure I. Potential for existing staff to relocate for a better work/life balance Linked risks 2131: Consultant Microbiologist Workforce Under Pressure 2807: Additional Staffing Required to Maintain Service Delivery (Microbiology)	Major	Likely	16	1) Reduce non-essential workloads where possible 2) Request staff to reschedule leave 3) Reduce routine quality activities 4) Offer overtime 5) Current Consultants covering additional workloads 6) Locum booked for shifts that can not be covered 7) Request support from SEND network 8) Consider Outsourcing	1) No guarantee that shifts can be covered 2) Backlogs continue to increase 3) National shortage in these specific roles may result in recruitment being unsuccessful 4) Cover provided may not include some key elements of the role 5) Unsuitable workload demand on existing staff 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. 7)Financial implications to outsourcing	30/04/2023	Major	Likely	16	[24/08/2023 17:01:44 Anthony Lowe] Currently recruiting to replace two 8b Lab managers Fragile services review for Histology and Microbiology ongoing in network. Locums etc will be used to maintain out of hours coverage until March 2024 [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 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. 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. Biochemistry under sever operation pressure du to band 5/6 maternity leave/sickness impacting on 24/7 rota. Under review with ADO [08/03/2023 14:43:47 Anthony Lowe] Process to recruit a new Histology manager has begun. Currently at job matching. Risks of recruitment of senior staff is recognised by South 1 Network but any actions could be long	Major	Unlikely	8						
2948	13/11/2020	Corporate Level Risk	Emergency Department (ED)	Lisa Houlihan	Nicola McMinn	Chief Operating Officer	Clinical Safety Risk		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. Effects: A. Delays in transferring patients to appropriate units due to bed availability. B. Poor patient experience. 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. 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. 3. DPT to provide guidance on supportive 1:1 requirement. 4. Once ED works complete the MH suite will return to its normal function - complete 5. Once ED work complete on the clinic room this will also provide a safer assessment environment.- complete 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 . [08/03/2022 15:16:28 James Merrell] No new changes to the risk. [03/12/2021 09:48:40 James Merrell] No changes to the risk	Major	Possible	12						
2957	19/12/2020	Corporate Level Risk	All Departments (Risk Only)	Kate de Burgh	Ria McCoy	Chief Nurse (Deborah Kelly)	Health and Safety Risk		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. RADIOLOGY HAS BEEN SELECTED AS THE LOCATION SIMPLY AS IT IS THE LARGEST USER OF IONISING RADIATIONS Cause: A significant number of inadequate controls regarding management of radiation safety (Ionising Radiations Regulations 2017-IRR17) have been identified. 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. Linked risk: 2928: Inadequate Medical Physics Resources Impacting on Service Provision (workforce risk) 3637: Lack of Dosimetry Management Process	Major	Likely	16	1) Radiation Safety Committee 2) Policies / Procedures / Systems for safe work	1) There are widespread gaps in controls across the organisation. 2) Lack of or inadequate radiation risk assessments 3) Lack of effective process and control of Occupational Dosimetry 4) Inadequate training in radiation safety - lack of mandatory training 5) Inadequate Local Rules 6) Local Rules not followed by Staff 7) Lack of Radiation Protection Supervisors for Controlled Areas 8) In adequate numbers of Radiation Protection Supervisors 9) Lack of process of Cooperation between Employers / Outside Workers 10) Inadequate contamination monitoring in Nuclear Medicine 11) Lack of programme for assessment and monitoring of Radon in the workplace 12) Poor overall management of radiation safety	04/08/2023	Major	Likely	16	[24/07/2023 16:42:20 Tim Simpson] arranging meeting with RPA asap [06/03/2023 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 laboratories 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. 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. Actions around this risk warrant review and updating	Major	Rare	4	To formally review this risk following the Radiation Safety Committee Meeting on 10/2/22.	Tim Simpson	04/08/2023			[24/07/2023 16:28:28 Tim Simpson] arranging meeting with RPA asap [21/06/2023 07:44:22 Tim Simpson] RPA has started but no availability to discuss before w/c 10/7, will arrange a meeting [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

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Torbay and South Devon NHS
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ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	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.
3316	12/11/2021	Corporate Level Risk	Building a Brighter Future / New Hospitals Programme	Christopher Knights	Christopher Knights	Director of Transformation and Partnership (Adat Jones)	Financial Risk		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 Effect: Risk in securing funding for the programme Linked to the following risks: 3270 BFF Commissioning - Workforce Risk (closed) 3269 BFF- Business Case Authorship - OBC and FBC (closed) 3268 BFF- OBC and FBC Business Case Authorship -(CIP) (closed) 3267 BFF: OBC Support Services- Lack of Efficiencies (closed) 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. 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.	01/11/2023	Major	Likely	16	[01/08/2023 10:37:38 Emily Widdicombe] Risk reviewed by CK, no updates required - rescheduled review date for 01/11/23. [27/03/2023 14:07:20 Sandi Clemo] Risk reviewed, no updates required - rescheduled review date for 01/06/2023 [07/12/2021 10:52:13 Amanda Anders (Risk Officer)] Agreed to add to CRR	Major	Likely	16						
3437	09/09/2022	Corporate Level Risk	PMU Operations	A&E	Emma Rooth	Deputy Chief Executive Officer	Operational Risk		Torbay Pharmaceuticals	HVAC Cooling Capacity Insufficient During Extreme Hot Weather	Cause: Extreme heat weather conditions. Impact: During extreme heat weather conditions, the temperatures in the GMP manufacturing and equipment preparation arees increase as the cooling capacity of the current air chillers is insufficient to maintain controlled conditions. The consequence of the increasing room temperatures leads to risks to products and revenue. 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. 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. 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 [05/01/2023 15:50:29 Kim Hodder] Review date amended to end of March 2023 [06/09/2022 11:32:03 Amanda Anders (Risk Officer)] Risk approved onto the CRR [05/09/2022 10:25:35 Kim Hodder] Risk & Action owner changed from Dawn Sowerby to Alun Rees [22/08/2022 13:00:27 Amanda Anders (Risk Officer)] Risk and ratings were approved at TP Board Meeting on Thursday 18th August.	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			
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Adat Jones	Director of Transformation and Partnership (Adat Jones)	Performance Risk	Business Intelligence Finance	HQ Regents House	Activity Dataset Non-Compliance For Community Setting	Cause: Non compliance in recording activity within the community setting. 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. 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. 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.	29/12/2023	Catastrophic	Possible	15	[12/07/2023 10:56:06 Neil David Elliott] The Data Engineering team have now taken over the submission of this data set from the agency resource. It is still a partial submission as the PARIS system does not comply with the requirements and that system needs to be updated in order that to get sufficient data to make a submission. John Broom is leading that project. [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. [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.	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	29/12/2023			[07/07/2023 11:41:44 Neil David Elliott] The partial submission of this dataset has now been taken on by the Data Engineering team. The work to make the data collection with the PARIS system compatible with the return requirements is still ongoing. [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. [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.
2965	30/11/2020	Corporate Level Risk	Maternity Services	Jonathan Hindley	Joanna Bassett	Chief Operating Officer	Clinical Safety Risk		HOS Torbay Hospital Delivery Suite	Access to an Emergency Theatre for Obstetric Cases	Cause: 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. Effect: 1) Inability to provide care within nationally recommended timescales, eg Category 1 LSCS within 30 mins. 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' 2) Review of position at each handover 3) Monday and Thursday - Theatre 10 (Griffin Suite) available 4) SOPS in place to support staff in and use of the emergency theatre team and enabling access to theatre out of hours.	1) Still potential that we are unable to go straight to theatre if clinically indicated.	27/11/2023	Catastrophic	Possible	15	[31/08/2023 16:01:07 Claire Jones] Update email received from Dave Brown, Matron for Theatres We presented the costs for 12 months of required agency usage, which was essentially refused. Unfortunately we therefore have no quick fix. We are now engaging with other Trusts looking at potentially recruiting anaesthetic technicians from overseas who may be able to register as OOPs in this country. This will take months if it turns out to be fruitful, but is reflective of the national situation. We are doing all we can to recruit. [31/08/2023 15:50:25 Claire Jones] Request sent to Dave Brown and Sharon Boyne requesting a Guideline around obstetric access to emergency theatres [26/07/2023 10:27:36 Claire Jones] Meeting held with Ian currie and agreement for OOP's to be sourced on the bank pending board agreement. Awaiting update on progress with Dave Brown and Sharon Boyne.	Catastrophic	Rare	5						
3293	14/10/2021	Corporate Level Risk	PMU Finance	David Houghton	Emma Rooth	Deputy Chief Executive Officer	Financial Risk		Torbay Pharmaceuticals	ITH Pharma- Loss of Future Revenues	Cause: Risk of loss of future revenues as a result of insolvency. 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. 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 [05/09/2022 10:04:29 Kim Hodder] TP continues to monitor ITH. [25/02/2022 15:08:49 Kim Hodder] Dave Houghton has spoken with Andrew Winstanley (Sales Director) at ITH Pharma. 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. 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. 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						