NHS
Torbay and South Devon
NHS Foundation Trust

Annual Report and Accounts 2021/22

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

Torbay and South Devon NHS Foundation Trust
Annual Report and Accounts
2021/22

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Foreword by the Chairman and Chief Executive

Welcome to our Annual Report for 2021/22. When we reflect on the challenges and achievements of the past twelve months we feel an overwhelming sense of gratitude.

Gratitude for our compassionate and skilled staff whose dedication to caring for the people who use our services is exceptional. Gratitude for our amazing volunteers and fundraisers whose contributions improve and enhance the care we are able to provide.

Gratitude for our partners who work closely with us to make the best use of the resources available to us so that together we can provide the best care possible. Gratitude to our members and our Governors for their interest, their challenge and their insight which makes us better leaders and a better organisation. And gratitude for the kindness and support we receive from our patients, their carers and the public each and every day. We are truly grateful and we thank you all.

It will take each and every one of us to achieve our vision of better health and care for all but we believe that we can do this, together.

Our highlights this year include the using technology in new ways to provide better care. Our HoloLens pilot brings clinicians directly into people's homes to support wound care leading to faster and more effective treatment and reducing the need for patients to travel. Building work has continued on our new health and wellbeing centre in Dartmouth which will bring together a range of health and care services for local people under one roof and we are making good progress with the new acute medical unit on the Torbay Hospital site – both are due to open in autumn 2022.

We became a carer confident employer (one of only two Trusts to receive this award) which demonstrates the high level of support available to those of our staff who, alongside their job, care for a family member or friend with long term physical or mental ill health, disability, or have problems related to old age. And we reinforced our commitment to partnership working within the developing Devon Integrated Care System. Towards the end of the year we were able to offer people on our waiting lists not only CT and MRI scans at the Nightingale Hospital in Exeter but also orthopaedic operations (hips, knees and other joints), helping to reduce the time people are waiting for care.

Many of the challenges we have faced, and will continue to face, are not unique to us. Or to the NHS.

Staffing is a critical issue not only for health services but also our partners in social care, domiciliary care and care homes. As the largest employer in Torbay and South Devon, it is vitally important that we further develop our local workforce, giving local people opportunities to work with us and supporting our communities to thrive. Our education team have been relentless in making sure our staff are able to maintain their training and development in spite of all obstacles. And thanks to the dedication

of our apprenticeship team, we can now proudly offer more than 50 different apprenticeships from intermediate to degree level across a wide range of clinical and support services.

Wehave also strengthened our international recruitment by joining, and hosting, the Devon International Recruitment Hub, an alliance of six NHS organisations. By working together, we have been able to recruit internationally in a more coordinated way and we are looking to expand our international recruitment into other professions both within healthcare roles, such as allied health professionals and doctors, and also social care.

Staff wellbeing is also at the forefront of our thoughts. The sustained high demand for our services coupled with the ongoing pandemic has generated significant pressure and stress. We know that people who are fulfilled and valued provide better and safer care and have the energy to develop new ideas and ways of working. Through our people promise we are working with our staff to create a workplace where each and every one can thrive.

Money and resources affect us all. Ensuring that we get the best value for every pound we spend while also supporting environmental sustainability is a key priority for us. The pandemic continues and this brings particular challenges for health services as we try to balance caring for those in acute and critical need with maintaining operations and treatment for people who are waiting in the community.

Over the past year waiting lists have continued to grow, our waiting times in our Emergency Department have also risen and we have struggled to get people home from hospital as quickly as we (and they) would like. We fully recognise the physical and emotional impact of waiting for care – whether this is waiting in an Emergency Department or an Urgent Treatment Centre, waiting to see a GP, waiting for a package of care to support returning home from hospital or waiting for a planned operation or treatment. Every person waiting for care is important to us. It is not easy for our dedicated staff either – they desperately want to care for those who need our services.

We know we need to work differently and provide services in different ways in order to reduce the waiting lists and make sure that everyone gets the care they need, when they need it. We are committed to doing this but know that we can’t do it alone – we are already working in closer partnership with other healthcare providers in our county through developments such as the Nightingale Hospital Exeter but we need to build on this. To help us make the most of the opportunities we have, we will need everyone’s continued support and flexibility to adapt to different ways of providing and offering care.

Throughout everything we do, we continually strive to improve and deliver excellent, high quality, safe care to our patients in partnership with them. We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them.

We believe that care as close to home as possible benefits everyone. This remains at the heart of our vision and our strategy.

Our building a brighter future programme is a key enabler to deliver our strategy and we will be using the once in a lifetime opportunity offered by our share of £3.7billion funding from the Government's health infrastructure plan to advance new models of care and service delivery while further developing our integrated care model. We will invest our share of the funding to build new hospital facilities, supported by local health and wellbeing centres and home-based care, making the most of digital technology to deliver better health and care for all.

Thank you once again for all your support this year. We will continue to work with you, and for you as we build the bridge to our brighter future together.

Richard Ibbotson, KBE, CB, DSC, DL

Chairman

21 June 2022

Liz Davenport

Chief Executive

21 June 2022

Part I – Performance report

Overview of performance

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

In this section, we highlight a number of the main developments to our services and the improvements we have made to the care we provide over the past twelve months, while also reporting on how we performed against key national and locally determined clinical standards.

The COVID-19 pandemic continues to have significant impact on the NHS and we experienced a notable, surge in the number of COVID-19 admissions in the last quarter of the year. This impacted significantly on us in terms of financial arrangements, operational performance and workforce.

This report outlines our position as at 31 March 2022 and provides commentary on relevant post year-end matters.

Chief Executive's statement on performance

We are under enormous pressure to meet the health and social care needs of a growing and diverse population, alongside great changes to the infrastructure of the NHS and a difficult financial climate. Our performance against a range of national targets and standards is assessed and reported externally.

The six priorities outlined in the 2021/22 operational planning guidance include supporting the workforce, delivering vaccinations and ongoing COVID-19 support, transformation to accelerate recovery of electives and address rising demand for mental health services, expanding primary care capacity to address health inequalities, transforming community and urgent and emergency care to reduce pressure on emergency departments, and system collaboration.

These measures include the 4-hour emergency care standard, cancer referral targets, infection control standards, 18-week waiting times, and staffing levels.

For most of the objectives or indicators, a rating of either Green or Red is applied based on the position to date against the threshold set. In some cases, an Amber rating is applied for reasons such as the objective/indicator area being currently on hold or as an early warning that an area being measured on a quarterly or annual basis is currently behind plan. Supporting commentary is provided together with trend charts showing the position over the previous five quarters or fifteen months, depending on the frequency of the measurement period.

The Board of Directors considers an Integrated Performance Report at each meeting which describes performance against these targets and any action being taken to

address dips in performance. This is informed by detailed review at Executive, Group and Committee level prior to each Board meeting.

Monitoring of performance during the year was delivered via the Integrated Service Units ('ISUs'), each of which is responsible for delivering services to their localities (Coastal, Moor to Sea, Newton Abbot, Paignton and Brixham, and Torquay).

Performance monitoring enabled each of the ISUs to review quality and performance dashboards relevant to their services on a monthly basis and to present plans where there were risks or concerns. There was also detailed scrutiny of the different elements of the Integrated Performance Report through the Finance, Performance and Digital Committee, People Committee and Quality Assurance Committee. At each financial quarter end, the Board confirms the position of each of these metrics to NHS Improvement. Details of our performance during the year can be seen below.

Our purpose and activities

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

We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them. We believe that care as close to home as possible benefits everyone.

We have a proven track-record of innovation both in terms of our integrated care services and with some of our specialist clinical services, for example day surgery, being nationally recognised for their best practice.

Never has our vision for better health and care for all, been more important. The impact of COVID-19 has not only increased the pressure across all aspects of health and social care, but those who live in our most deprived coastal communities have seen an increasing gap in health inequalities.

As a well-established integrated care organisation (ICO) of more than seven years' standing we know at first hand the positive impact that working together in partnership with others has for our local population – giving everyone a brighter future.

We work with many different communities: our patients and their carers, family and friends, our staff, members and governors, care home and domiciliary care providers, our NHS colleagues in Devon and the wider south west as well as colleagues in the private sector, and our public and voluntary sector partners. Working together, we share and learn from our combined experience and expertise

so we can provide the very best care and services for our local people, whenever they need us.

We serve our local people by providing community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites. Increasingly, we are providing more care as close to home as possible for our people, reducing their need to travel and helping to keep them safe and live well. More and more we are delivering care directly into people's homes either through visits or online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in a number of community locations. Due to the COVID-19 pandemic and recruitment difficulties, we have had to reduce the number of community sites offering urgent care – this has meant the temporary closures of our minor injury units in Dawlish and Totnes. The urgent treatment centre in Newton Abbot has remained open 7 days a week and offer an x-ray service.

We support around 500,000 face-to-face contacts with patients in their homes and communities each year and see over 78,000 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

We have been given a share of £3.7 billion government funding for a new hospital development. This is a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people. It is not just about building a better hospital in Torquay. It is about building a brighter future for all of us.

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

We cover a wide geographical area, including parts of Dartmoor (Newton Abbot, Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes and Dartmouth. We employ over 6,700 staff in order to deliver and manage our many services, from porters to consultants, nurses and health care assistants to 'hotel' and catering staff, therapists and security staff….and there are many more! We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

We currently have a total of 476 active volunteers comprising of 441 Senior and 32 Youth volunteers (16-25). There are 208 volunteers who are inactive due to not being fully vaccinated, have a medium to high individual risk score, are not comfortable in returning yet or their role has not resumed. We have 12 on hold for

various reasons and a further 24 currently going through their recruitment checks and training.

There are approximately 113 volunteering for charities - Torbay, Lifecare and Tower Sound Hospital Radio and League of Friends, all of which are included in the total figure of 476 active volunteers. We are focussed on rebuilding the volunteer base to replace those that stood down as a result of the COVID-19 pandemic.

Our operating income for 2021/22 was £602 million. Devon Clinical Commissioning Group (CCG) commission our main acute and community services. Devon County Council and Torbay Council commission our adult social care services and our public health nursing services. Devon CCG also commission our children's health services, for which we are the leader in an alliance with other Devon organisations. We have continued to forge many strategic and business partnerships in order to strengthen and improve our services as detailed below:

- we are the lead organisation in the alliance of Children and Family Health Devon (CFHD) which began in April 2018. Our other alliance members are NHS partners Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare NHS Trust and Devon Partnership NHS Trust, as well as social enterprise company Livewell Southwest
- we have until recently been a partner in Health and Care Innovations LLP providing health care videos developed by clinicians and specialists for our patients to access online. There is a memorandum of understanding on working arrangements with Rocklands Media Limited
- we have a wholly owned subsidiary (SDH Developments Limited) providing an on-site pharmaceutical dispensary at Torbay Hospital
- we are a partner in a Limited Liability Partnership (SDH Innovations Partnership LLP), which is supporting our ambitions to replace out-of-date facilities with new buildings
- we are part of University of Exeter's Academy of Nursing, along with three other Devon NHS Foundation Trusts
- through Torbay Clinical School, we are in a partnership with Plymouth University to promote clinical research
- more recently, we established a strategic partnership with North Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust which supports us to work together more closely to secure sustainable, high-quality care for everyone for the future
- in 2021, we became a core part of the South Local Care Partnership with our NHS, council and voluntary sector partners. There are five local care partnerships across the county which form a key part of the Devon Integrated Care System
- we are continuing to forge closer partnership with South Devon College to align our workforce and education strategies.

During the past twelve months, our numbers of patient contacts have been slightly lower compared to previous years. This was in part due to the impact of the COVID-

19 pandemic and the effect it had on all our lives as well as the changes it made to how people access services.

We treated over 66,000 people in our Emergency Department and 32,500 in our Minor Injury units and Urgent Treatment Centre. The number of face-to-face contacts with patients in the community is over 200,000.

History and statutory background of the Foundation Trust

Torbay and South Devon NHS Foundation Trust is a statutory body which, in October 2015, became a public benefit corporation, following its approval as an NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts authorised under the Health and Social Care (Community Health and Standards) Act 2006.

Torbay and South Devon Foundation Trust ('the Foundation Trust') was established on 01 October 2015, following the acquisition of Torbay and Southern Devon Health and Care NHS Trust (providing community and adult social care) by South Devon Healthcare NHS Foundation Trust (providing acute services), thereby enabling the new organisation to implement a new model of integrated care. In creating ourselves as an integrated care organisation, a financial risk share agreement was established with our partners, which has stood us in good stead and enabled major changes to how health and care is delivered for our local population.

The principal location of business of the Foundation Trust is Torbay Hospital, Lowes Bridge, Torquay TQ2 7AA.

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

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

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

- assessment or medical treatment for persons detained under the 1983 Act
- diagnostic and screening procedures
- family planning services
- management of supply of blood and blood derived products
- maternity and midwifery services
- personal care
- surgical procedures
- termination of pregnancies
- transport services, triage and medical advice provided remotely
- treatment of disease, disorder or injury.

As a Foundation Trust responsible for public funds, the Board of Directors is accountable to local people represented by the Council of Governors. Full guidance on how Foundation Trusts are required to operate is available from NHS England / NHS Improvement (NHSEI).

Our year in highlights

It has been a tough and challenging year. We have experienced sustained high demand for services, seen waiting lists and times grow, despite everyone's best efforts, and COVID-19 has continued to impact our ability to care for people as we would wish.

Throughout it all, our people have worked really hard to deliver the best care they can, harnessing their creativity and curiosity to keep our patients at the centre of their care and integrate services around them. Together with our staff, patients, carers, volunteers, governors and partners we have worked to shape our vision for better health and care for all, while providing care as close to home as possible.

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

App extends access to 24/7 expert care

Our CONNECTPlus app, developed in partnership with local company Health and Care Innovations, has expanded and is now helping people manage many more – and even multiple – health conditions from their own phone or device, day or night, wherever they are. CONNECTPlus was initially developed for people with osteoarthritis and multiple sclerosis (MS) and now supports diabetes, gastroenterology and orthopaedics, with cardiology and respiratory services due to be available in the next few months.

The app not only helps people to learn more about their health conditions but supports them to manage appointments and medication, to monitor and track their symptoms and provides information on when and how to contact their health and

care team. The app was shortlisted for the Health Service Journal's Driving Efficiency through Technology award and won the national Building Better Healthcare Award for best patient-centred healthcare software.

'Virtual' appointments
We provided over 70,000 virtual appointments by video and telephone, supporting people to be seen in their own home, benefiting both patients and communities by reducing the impact on the environment from travel and giving people back the time that they would have previously spent travelling, finding parking and waiting to be seen.

We carried out a survey of more than 1,000 patients to find out what people thought about having their appointments this way instead of face to face. Over 90% felt their needs were well or very well met.

HOPE programme builds confidence
We extended our HOPE programme, which helps local people struggling with long-term health conditions to build confidence and learn how to manage their condition(s) better. This year we introduced courses for people who have become new parents and for people living with long COVID. We also have set up a course specifically for health and care staff living with long COVID.

Peer coaching programme
We expanded our Health Connect coaching programme which uses a person-centred approach to combine peer support with the value of shared lived experience with someone who 'just gets it'. Volunteers (our staff, patients, members of our local communities, and more) are recruited, trained, supported and carefully matched with peers to use health and wellbeing coaching skills over a six months structured programme.

Helen Davis-Cox, Head of Personalised Care, became a national clinical entrepreneur for her work on peer patient coaching.

Support for people living with cancer
Our cancer services launched a 5k your way to encourage people living with and beyond cancer, and their families and friends, to get active outdoors in a supportive environment. While colleagues in head and neck cancer services welcomed a new patient-led support group in partnership with The Swallows Head and Neck Cancer Support – the first of its kind in the south west.

Reducing inequity and building a health community with local partners

Supporting recovery from substance use
Together with partner organisations including the Jatis Project, Steps Forward and social prescribers working in primary care, our Torbay drug and alcohol service

established a community group of people in recovery from substance use (TARGET). TARGET has gone from strength to strength. It offers a broad range of physical, creative and volunteer activities, which connect people together and benefit local communities while providing peer support.

Putting charitable donations to good use
Through our COVID-19 fund appeal and NHS Charities Together we supported the development of new outdoor space at our Bayview restaurant at Torbay Hospital. Bi-fold doors have been installed and new seats, tables and planters mean that the new outdoor space will provide a better environment for staff, patients and visitors. We planted twenty trees across our Torbay Hospital site, as a lasting symbol of life and hope for the future while improving our hospital environment.

We worked with community organisations and other NHS organisations in Devon to ensure that local people will benefit from monies donated to NHS Charities Together during the pandemic through their community partnerships grants programme. The aim of the programme is to improve the health of communities adversely affected by COVID-19. Rowcroft Hospice, Healthwatch Torbay and the Torbay Community Development Trust will all benefit from the funding which will support projects for two years, including Rowcroft Hospice's hospice at home service.

Our Leagues of Friends continued to be a source of great support to us and continued to fundraise despite the pandemic. Donations from our Leagues of Friends this year included two stairclimbers, which help people with limited mobility travel using our patient transport and a new tool for training surgeons - a laparoscopic bile duct ultrasound model.

A better hospital experience for children
Our paediatric team worked together to improve the hospital experience of children and young people who have neurodiversity or experience emotional distress. They sourced funding to improve the availability of equipment and aids including weighted blankets, a 'magic carpet' interactive floor projector and other audio visual, tactile and sensory equipment. They also established a network in every hospital in Devon and Cornwall (plus Taunton) to share good practice, explore ideas for improvements and provide peer support and training.

Working with local communities
We are working with Dartmouth Town Council to explore whether the community can buy the former Dartmouth and Kingswear Community Hospital site and whether its redevelopment could include uses specifically to benefit people in and around Dartmouth. As a public sector organisation, there are some rules we have to follow when we sell any land or buildings, including making sure we get a fair price. But that doesn't mean we have to sell to the highest bidder. We are really keen to see local people benefit from any development, and are doing everything we can to support this community bid.

Black History Month
We celebrated Black History Month with lots of wonderful events and activities as well as challenging conversations, as we explored what 'proud to be' meant to our colleagues. We ended the month with an online event with Alexandra Ankrah (Health Education England), Dr Habib Naqvi (Director of the NHS Race and Health Observatory), Michael Caines MBE (celebrity chef and local resident), and Tanya White (Physician Associate at Torbay Hospital). During the event, hosted by Sir Richard Ibbotson and Liz Davenport, our guests shared their stories and reflections on the theme of 'proud to be', followed by a question and answer session.

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

Nursing excellence
We are one of only 14 trusts in England to be selected to take part in the internationally recognised Pathway to Excellence® accreditation programme. The global programme is a 'nursing excellence' framework, aiming to create a positive practice environment for nursing and midwifery staff that improves nurse satisfaction and retention. As part of this work, we have established more than 10 team-based councils and a similar number of theme-based councils to focus on shared decision-making and quality improvement. One example of how the councils are making a difference is that, wherever possible, maternity staff are now offering follow-up care closer to home for women who have recently given birth.

Our ward accreditation programme aligns with the Care Quality Commission core standards and makes sure that the care we deliver is standard across every area. This year we established it in our inpatient areas and developed our plans to roll it out more widely across community nursing services over the next year. 17 wards have currently been assessed with 9 golds, 7 silvers and 1 bronze awarded.

Using latest technology to improve healthcare
We are proud to be a national pilot centre for trialling the ground-breaking Microsoft HoloLens 2 and Dynamics 365 Remote Assist. A mixed reality headset, HoloLens 2 uses multiple sensors, advanced optics, and holographic processing. The digital overlays created within the headset can be used to display information which blends with the real world to create a mixed or augmented view.

The first pilot project is taking place at our Breast Care Unit supporting nurse-led dressing clinics. Clinical specialist nurses are able to send a high-resolution video feed to consultants, in real time, to get immediate feedback and advice on a patient's needs. Additionally, consultants are able to add digital markers and annotations live on to the video, to guide the nurse's view where useful. This replaces the current system of emailing static images to consultants.

Raju Ramesh, Consultant Orthopaedic Surgeon, developed Torbay Charts, a novel interactive digitally-enabled patient decision aid that can be used in all stages of the patient journey in various musculoskeletal pathways to enable shared decision making between patients and clinicians. It was identified as best practice by the

national Get It Right First Time (GIRFT) team and adopted by Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group as an integral part of their systematic roll out of shared decision-making in the musculoskeletal pathways in their region.

Taking part in cutting-edge research
We became the first trust in the south west to open the PACE trial to treat prostate cancer patients. This involves the use of a new technique called SABR which uses advanced imaging technologies with sophisticated computer planning to safely deliver precisely targeted radiotherapy using fewer, higher doses of radiation. This means patients attend hospital for as few as five visits as opposed to many more over several weeks.

We opened a new study which will investigate a blood test that helps detect cancers earlier. The nationwide SYMPLIFY study, supported by the National Institute for Health Research, will investigate a new multi-cancer early detection (MCED) test in the NHS, known as Galleri, for patients with non-specific symptoms that may be a result of cancer. Using revolutionary next-generation sequencing technology, Galleri has the potential to identify multiple types of cancers at earlier stages of disease compared with traditional diagnostic methods, which should increase the chance of successful treatment and improve outcomes for patients.

Building a healthy organisational culture where our workforce thrives

Caring for our people
We affirmed our people promise and plan to support us to care for our staff and refreshed our staff awards to base them around our people promise. Our People Awards launched on Valentine's Day following the closure of our Staff Heroes Awards in December 2021. Our Daisy Awards, recognising outstanding contributions to healthcare from nurses, run throughout the year and awards are made monthly.

We became one of only two NHS organisations to be recognised with an award for supporting staff members who care for someone outside of work. We have gained the Carer Confident Employer, Level 2 'Accomplished' Award which demonstrates the high level of support available to the many staff members who, alongside their job, care for a family member or friend with long term physical or mental ill health, disability, or have problems related to old age.

We have over 120 wellbeing buddies in clinical and corporate teams across a number of our sites. Our wellbeing buddies offer a truly local first line of support and signposting to anyone who needs to reach out for that little bit of extra help that we all need from time to time.

Our people have told us, that in times of challenge they turn towards colleagues, their immediate team and family and friends for support. It is these trusted relationships that help us to feel safe to talk openly. We have built on this and are supporting and upskilling small groups of wellbeing buddies within each team to provide people with the confidence to offer compassion, empathy and a listening

ear. Our wellbeing buddies are there for colleagues when times get tough.

Recognition for individuals
Dr Rhoda Allison, Associate Director of Nursing and Professional Practice (Moor-to-Sea) was awarded an MBE in the Queens's new year's honours list for her services to physiotherapy while Dr Cathryn Edwards, consultant physician and gastroenterologist was awarded an OBE in the Queen's birthday honours.

Chantal Baker, Nursing and Midwifery Excellence Lead Nurse, received the silver Chief Nurse Officer's award from Ruth May, Chief Nursing Officer for England. Two community children's nurses from Children and Family Health Devon, Laura Ireland and Jo Broderick, and two nurses from our community services, Stacey Tranter and Marcia Doherty, became Queen's Nurses.

Improving access to specialist services through partnerships across Devon

Creating extra capacity
Towards the end of the year the Nightingale Hospital Exeter opened as an important resource to provide additional capacity for the NHS in Devon. Around 160 of our patients each month are now benefitting from appointments at the Nightingale for MRI and CT scans and since March 2022 some of our patients have been offered orthopaedic operations there.

Our urology service has been working at weekends and travelling out of our local area to reduce waiting times for our patients – using operating space at Ottery St Mary and Tiverton to provide the care that people need. For two weeks in early 2022, a mobile urology unit was brought onto site at Torbay Hospital, performing more than 100 additional procedures including 51 prostate biopsies and 61 cystoscopies.

Taking part in research
A collaboration between our research team and researchers at University Hospitals Plymouth has delivered the highest UK recruitment into the national Valneva (VLA2001) COVID-19 vaccine study, surpassing our target and giving 268 local residents the chance to be involved in this crucial study, which has found Valneva to be a safe and effective vaccine.

Participants had an overwhelmingly positive research experience and out of 148 participants who gave feedback in the NHS 'Friends and Family test' 147 classed their experience as 'very good', and 1 classed it as 'good'. People commented on the professionalism and knowledge of the team and how enjoyable the research experience was.

Improving financial value and environmental sustainability

Catering 5* service
Our catering services received a 5* rating from the Environmental Health Officer. This is testament to the partnership between facilities staff and staff side colleagues in redesigning the ward facilities services and introducing bespoke ward catering assistants.

Our green plan
Over the past few years we have invested in high-efficiency LED lighting to reduce electricity demand, drastically cut emissions from volatile gases used for anaesthetics, made strides to reduce single use plastics in clinical settings, increased the amount of food sourced locally, supported staff to work remotely to reduce commuting and contributed to the NHS tree planting scheme.

Despite the positive progress we have made, it is now critical that we step up our commitment, affirming this at a leadership level and driving a more holistic approach to sustainable development and we are proud that during the year our Board of Directors approved our green plan, which will reduce our carbon footprint and improve our sustainability.

Investing in our estate
Building work started on our new Acute Medical Unit (AMU) at Torbay Hospital in March 2021 and has progressed well this year. The new unit is essential to reduce overcrowding in our Emergency Department and will make sure that our patients receive timely, high quality care, in the right place while providing significantly more assessment spaces. The AMU is due to open in autumn 2022 as is the new health and wellbeing centre in Dartmouth.

We are using the monies we will receive from selling the former Dartmouth hospital site to fund our contribution to the new health and wellbeing centre in the town. Building work began on the new centre during the summer which will give local people access to a broad range of health and wellbeing services in one place, by bringing together GPs, community nurses, therapists, Dartmouth Caring and a pharmacy.

Investing in new equipment
We invested in new equipment for Torbay Pharmaceuticals to increase its production capacity and future-proof operations at its Paignton site. Torbay Pharmaceuticals employs over 200 people in Paignton and beyond, supplying NHS and private sector pharmaceutical customers regionally, nationally and internationally. The investment saw a new high-speed vial line installed which allows us to increase production capacity, providing opportunities for more skilled jobs locally over the coming years.

Innovative estates partnership
Our joint venture partnership with gbpartnerships Ltd, SDH Innovations Partnerships LLP (SDHIP), was shortlisted for the private/public partnership of the year category in the Health Investor Awards 2022.

SDHIP is a 50:50 Joint Venture Partnership between ourselves and gbpartnerships (gbp), via gbp's wholly owned subsidiary, Health Innovation Partners (HIP). It is a leading example of how the NHS Strategic Estates Partnership (SEP) private/public partnership model can be effectively utilised to improve health and care services and value for money for the NHS.

Through this innovative partnership we are able to deliver greater value to our local communities than we could do alone, supporting us in our vision for better health and care for all.

Throughout the year, we continued to face a number of challenges which were exacerbated by the continuing COVID-19 pandemic. Put simply COVID-19 has made the work we do harder. The world has changed, and we need to change how we work and how we work together in order to provide better health and care to all.

Our challenges are shown below and described in more detail within the performance analysis section and the Annual Governance Statement:

Our financial risks related to:

- achieving efficiency savings for 2021/22
- continued financial impact of actions to recover from the COVID-19 pandemic
- our capacity to deliver activity to the required standards and activity levels.

Our quality and safety risks related to:

- the ability to maintain safe, quality patient care and achieve best patient experience during the continuing COVID-19 pandemic
- the requirement for social distancing during COVID-19 on patient health and wellbeing
- the availability of specialist staff compromised by the additional demands placed on specific specialities as a response to the COVID-19 pandemic.

Our risks to our people included:

- the risk of physical and mental consequences directly as a result of providing care to patients with COVID-19
- the toll on staff health and wellbeing as a consequence of the need for rapid and changes to working practices.

A number of operational risks were also identified. These included:

- the ability to deliver the required activity levels given the sustained impact of COVID-19 increase in demand for services
- the ability to deliver several national access standards, particularly the cancer maximum 62 day wait, the 18-week referral to treatment target, the 52-week waiting to start treatment standard and the diagnostic test six-week wait
- the impact of COVID-19 on national access standards resulting in reduced attendance at accident and emergency and minor injuries centres, the standing down of elective capacity, reduced capacity for surgical treatment and diagnosis, including testing.

During the year, in partnership with our people, we refreshed our organisational strategy, building on the core principles of the strategy we developed with local partners in 2005. This is when we began integrating health and social care services and we have brought together our learning from the past seventeen years to evolve and refine our thinking, determining our strategic priorities as we build a brighter future for everyone in Torbay and South Devon.

Our vision is better health and care for all.

Our values and the NHS Constitution

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

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

We make sure that everyone counts and that every voice is heard. What matters to our people matters.

We are strongly committed to improving the quality of everything we do and working with compassion, dignity and respect at all times.

Our values are:

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

Our partners

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

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

Integrated Care System – the Devon long-term plan

The Integrated Care System (ICS) in Devon was designated on 01 April 2021, bringing health and care organisations together to work in partnership to deliver our shared ambition “Equal chances for everyone in Devon to lead long, happy and healthy lives”. This approach led by Local Authorities, the NHS, voluntary sector and other partners, focuses on a person-centred approach to supporting everyone in Devon by providing a wide range of support to meet their needs. This will include everything from mental and physical health, to housing, education and social care. The ICS partnership is also focussed on tackling the wider determinants of health, addressing inequalities and moving to more preventative and anticipatory care.

As a key partner in the ICS, we are committed to delivering our shared ambition through the Devon long-term plan, which was developed over this first year and is reflected in our organisational strategy. Our six ambitions as a system are:

- efficient and effective care
- integrated care
- community and people led change
- children and young people
- digital Devon
- equally well in Devon

Financial position

NHS England and NHS Improvement (‘NHSEI’) issued revised arrangements for NHS contracting and payment during the COVID-19 pandemic in March 2020. The financial framework was further refined nationally during the year, which was approached in two six-month periods. COVID-19 funding was, in the large part, fixed. We delivered on our commitments within the funding envelope available. Furthermore, we benefitted from additional funding through the hospital discharge programme and a number of Local Authority grants, designed to improve infection control processes and support workforce sustainability in the domiciliary, residential and nursing care sectors.

The effects of COVID-19 affected all parts of our health and care services, including supply chains vital to us in the provision of our services. Maintaining business continuity and financial sustainability therefore was important, particularly the payment of staff and suppliers and the maintenance of cash flow. We were able to respond and concluded the year showing a balanced financial position. Despite this, the requirement and focus to deliver year on year efficiency savings, investing in developing technology, maintaining an aging estate, and, responding to increasing demand and COVID-19 pressures continued.

Operational services

The government launched a series of public information campaigns, which continued throughout the year, to highlight the risk of NHS capacity being overwhelmed due to the COVID-19 pandemic. Bed capacity, particularly the ability to treat patients with

breathing difficulties remained a key risk during the year. We retained our operational COVID-19 escalation to support workforce resilience and emergency bed capacity to ensure any sudden peaks in demand could be managed along with heightened emergency pressures. We also worked closely with neighbouring provider trusts in the Devon system in order to deliver a system approach for managing demand for services.

While there was no significant change in numbers of patients attending Accident and Emergency (A&E) in 2021/22, the aging estate and difficulties in discharging patients to step down settings of care, impaired our ability, at times, to manage patient flow at an optimum level. This also placed additional pressure on the staffing levels across all services and also affected staff morale. However, we responded to address the changing needs of our local population and pathways of care through targeted investment in the physical environment, including redevelopment and repurposing of outpatients space, significant modifications to the Emergency Department, and ongoing improvements to ward environments, both within Torbay hospital and wider community estate.

Performance

The COVID-19 pandemic had an adverse impact on the final end of year reported performance and we did not deliver the level of performance expected against all the key NHSEI performance standards. The challenge into 2022/23 will be to respond to the changing needs of health care services as the COVID-19 pandemic continues, balancing the provision of services for the most clinically urgent patients while supporting longer term recovery plans for people requiring more planned care, many of whom have been waiting a long time for their diagnostic interventions or surgery.

A summary of the key clinical access performance standards used by regulators to assess our performance is set out below in the performance analysis section.

Our people

The protection of staff and patients was a major concern during the COVID-19 pandemic. We have continued to follow national and local guidance in our response to the virus as well as continue to ensure availability of medically fit staff to provide care for our patients and the NHS nationally. This has been significantly challenging so there remains a continued focus on ensuring we support staff health and wellbeing, physical and mental wellbeing, as well as to deploy the staff available to the clinical areas where they are most needed.

COVID-19 Immunisation Programme

In January 2021 the trust commenced the COVID -19 immunisation programme, undertaking the primary course to Trust employed staff with an uptake of over 93% of staff receiving the full primary course of two doses. From April 2021 – March 2022, the Trust also provided this programme to the wider health and social care community which included 3,000 other NHS staff and 9,000 Local authority, pharmacy, funeral directors, Rowcroft hospice, Mount Stuart Hospital and independent allied Health Professional colleagues. In total, just under 19,000 Trust and other health and care colleagues across our local community were immunised.

Transformation and partnerships

During 2021/22, we continued to make progress in the development of our transformation and partnership working with our LCP and our ICS. These relationships have become more important throughout the pandemic in providing an immediate response or support from system partners to maintain services for local people. Our organisational strategy outlines our commitment to playing our part in the delivery of the Devon long-term plan as a key provider of services in the ICS.

As we develop our plans for Building a Brighter Future, our purpose to support the people of Torbay and South Devon to live well, will be realised through the effectiveness of these partnerships and our appetite to transform our services across the system using digital as an enabler for change.

Our improvement and innovation team have developed four pillars of improvement on which we will deliver our strategic objectives, these include:

- building capability for quality improvement
- cost improvement through transformation
- our improvement programme
- strategic transformation and innovation.

Going concern

The Foundation Trust's financial statements have been prepared on a going concern basis.

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

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

Performance analysis

National and local standards

Our performance overview provides information about how we have performed against key regulator standards during the year. For this year (2021/22) the standards remain as those described in the 2019/20 Single Oversight Framework.

During the reporting period, performance reports were provided monthly to the Finance, Performance and Digital Committee, and the Board of Directors. These

reports covered all the key national and local performance standards to provide assurance to the Board.

In line with the annual plan requirement to set out our performance against indicators described in the Single Oversight Framework (2019/20), our performance against the key indicators is:

	Target	Apr-21	Jun-21	Sep-21	Dec-21	Mar-22
NHS I - OPERATIONAL PERFORMANCE						
A&E - patients seen within 4 hours	>95%	84.4%	72.6%	65.1%	62.5%	58.4%
Referral to treatment - % Incomplete pathways less than 18 weeks	>92%	62.7%	64.4%	57.4%	55.6%	52.0%
Cancer - 62-day wait for first treatment - 2-week-wait referral	>85%	71.8%	68.8%	73.3%	61.9%	59.5%
Diagnostic tests longer than the 6 week standard	<1%	36.3%	32.2%	32.6%	37.9%	36.8%
Dementia - Find - monthly report	>90%	96.7%	97.4%	92.7%	87.3%	93.6%

4 Hour Emergency Department (ED) waiting times: performance continued to reflect the impact of caring for patients with COVID-19. Delays in our ED have been primarily due to pressure on beds for patients requiring ongoing admission for inpatient treatment. The bed pressures experienced are driven by increased patient length of stay due to complexity of care, infection prevention and control (IPC) measures, and delayed transfers of care once medically fit to leave hospital. Discharge pathway delays continue to be impacted by reduced capacity across the independent sector for nursing, residential home placements, and domiciliary care packages. The high bed occupancy rates then translates to delays at the emergency front door for assessment, transfer to inpatient beds following decision to admit, and increased ambulance handover times.

In January 2022 an additional 26 acute beds were opened to ease high bed occupancy pressures to improve patient flow. In response to the increased number of delayed discharges seen, through continued investment and focus on pathways of care, there has been a reduction in quarter 4 in the daily number of patients medically fit for discharge occupying a hospital bed. However, ambulance handover delays and maintaining patient flow has continued to be a challenge.

Referral to Treatment (RTT) access times: the impact of the COVID-19 response has meant a continued stepping down of elective care particularly for the routine and less urgent treatments. The Day Surgery Unit was re-purposed to support emergency care over the winter period with a subsequent loss of elective day-case capacity. As a consequence, waiting times have continued to increase with the number of patients waiting over 52 weeks increasing from 1,876 (April 2021) to 2,759 (February 2022) and 104 week waits from 6 to 243 by March 2022.

In the outpatient setting, the focus has been on returning to pre-COVID-19 levels of activity and increasing the number of non-face-to-face appointments where possible. Additionally, we have rolled out the advice and guidance pathway for initial GP referral response as well patient initiated follow up (PIFU) whereby patients are

discharged rather than booked for a routine follow up with the ability to request a further review should they need it.

Cancer standards: we maintained our commitment to prioritise delivery of cancer treatments. However, increased referral demand coupled with pressures in diagnostics, theatres, beds, and staffing including capacity for 2-week wait clinics over the year has meant that there has been an overall deterioration in performance. We have not met the standards for the 62-day referral to treatment, 28-day faster diagnosis, and two-week urgent referral standards.

Given the competing demand on clinical service capacity and processes to respond to COVID-19 escalation, the actions taken to preserve capacity for cancer pathways has, however, supported performance and mitigated further deterioration and significant impact upon patient care outcomes.

Diagnostics: demands for diagnostic tests has continued to increase with the delivery of required levels of capacity in CT and MRI dependent upon the insourcing of additional capacity using mobile units. From November 2021 the Nightingale Hospital Exeter has also been used to support additional CT and MRI capacity.

Recruiting to staff vacancies across the major diagnostic specialties had remained a challenge throughout.

Endoscopy services has used weekend insourcing throughout the year to stabilise waiting lists. The management of COVID-19 IPC constraints for aerosol generating procedures remain a challenge and continues to impact on efficiency.

Dementia assessment: the assessment of patients who were admitted to hospital over the age of 75 for dementia was introduced as part of the updated Single Oversight Framework in October 2017. This standard (90%) was achieved in aggregate for the year, with 94.5% of qualifying patients receiving timely dementia screening on admission to hospital.

Equality of service delivery: we maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have adopted a process of contacting patients by telephone as well as letter to agree appointment dates and follow-up appointments when initial contact with patients is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should a patient's condition change or they fail to engage with offered appointments.

The Devon System is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital Exeter as a system resource to support additional capacity for diagnostics, orthopaedic and ophthalmology treatments.

Assurance and performance monitoring: bi-weekly assurance meetings are held with operational leads, led by the Chief Operating Officer, to review the key NHSI performance standards and to review operational plans throughout the year.

These meetings are in addition to the monthly ISU, executive-led, Integrated Governance Group (IGG) Meetings where performance is reviewed with system leadership teams following each ISU's monthly governance process.

This process gives the Executive Team and Board of Directors assurance in relation to performance monitoring, escalation of performance risks where additional support is needed, and actions being taken.

Financial performance

Funding overview

The Foundation Trust earned over £602 million of income during 2021/22, primarily from clinical activities, but also received a significant contribution from education and training and other income generation activities.

In 2021/22 the majority of the Foundation Trust's clinical income continued to be received through block contract income streams received via Devon Clinical Commissioning Group and Torbay Council, plus a top-up income stream through NHS England to help NHS organisations respond appropriately to the COVID-19 pandemic. Infection control grant income received through Torbay Council was also used to support the residential and nursing home care providers' response to the COVID-19 pandemic.

The funding arrangements for the 2022/23 financial year continue to be mostly block contract related, but less financial support is now in place for the Foundation Trust's response to COVID-19. Greater financial emphasis is also being placed on earned Elective Recovery Income to reduce waiting lists on planned care pathways.

Given a considerable planned reduction in income during 2022/23, totalling circa £34m, and significant inflationary cost pressures on consumables and care services provided by the Independent (out of hospital) Sector, the Trust is forecasting a deficit of circa £31m during 2022/23. During this period of time, interim support in the form of Public Dividend Capital (PDC) from the Department of Health and Social Care (DHSC) will be accessed to ensure that adequate financial support is in place throughout 2022/23.

Value for Money

As an NHS Foundation Trust, we focus on ensuring the best possible economy, efficiency, and effectiveness in the use of resources. We aim to provide the best possible health and social care within available resources. Ensuring value for money in all the Foundation Trust's activities is therefore a fundamental part of our financial strategy.

However, due to the COVID-19 pandemic NHS organisations were during 2020/21 and 2021/22, instructed by the Department of Health and Social Care to focus on responding to the crisis and not to focus significant efforts on reducing cost bases. As NHS organisations now move out of the crisis mode of responding to COVID-19, there is renewed focus on delivering sustainable savings, some of which may be driven from the different approaches the Trust adopted whilst delivering care through the pandemic. The Foundation Trust is targeting the delivery of recurrent savings

totalling £25.2m by 31 March 2023, supplemented by non-recurrent savings within year totalling £3.2m.

To help demonstrate value for money, the Foundation Trust uses benchmarking information such as the NHS productivity metrics. For procurement of non-pay related items, the Foundation Trust has a procurement strategy which maximises value using national contracts and through collaboration with other NHS bodies in the Peninsula Purchasing and Supply Alliance.

Under the new National Audit Office ('NAO') Code for 2022/23, the Foundation Trust's external auditor, Grant Thornton LLP, will issue an Auditor's Annual Report providing a commentary on the Trust's arrangements to secure Value for Money. This will be reported to the Foundation Trust in September in accordance with NAO's timeline for 2021/22.

Capital developments during the last year

During 2021/22 the Foundation Trust continued to invest in its facilities and equipment and carried out capital projects totalling £37.7 million. In addition to this sum, the Foundation Trust received charitable donations totalling £0.3 million. Part of the Foundation Trust's capital expenditure has been supported by the Public Dividend Capital received from the Department of Health and Social Care, and through other sources of financing such as finance leases with commercial providers.

Cashflow

The Trust's cash position has decreased, from a starting point at 1 April 2021 of £45.4m, to a sum of £39.3m at 31 March 2022. The reduction in cash balance has primarily been used to fund extra capital expenditure during 2022/23 coupled with movements in the Trust's working capital, these being a higher level of debtors partly offset by increased trade and other payable creditors at 31 March 2022.

Other liabilities and Trade and other payables - creditors totalling circa £23.9m will however partly unwind over the first part of the financial year 2022/23 as suppliers' invoices become due for payment and as deferred income performance obligations are met.

During 2022/23, the Foundation Trust will continue to maintain detailed cashflow forecasts to assist with cash planning. Where necessary the Foundation Trust will request financial support from arrangements that are proven and already in place with the Department of Health and Social Care to ensure that the Foundation Trust continues to meet its contractual obligations to suppliers, staff and other government agencies.

Financial framework

Being licensed as an NHS Foundation Trust means that the Foundation Trust, as well as being more accountable to its local public and patients, has greater financial freedoms. NHS Foundation Trusts are free to retain any surpluses they generate and to borrow to support investment.

As noted in Part II of the annual report, the Foundation Trust's financial performance is monitored by NHS Improvement.

Accounting framework

As an NHS Foundation Trust, we apply accounting policies compliant with the Department of Health and Social Care's Group Accounting Manual (GAM). The DHSC GAM includes mandatory accounting guidance for DHSC group bodies completing statutory annual reports and accounts. These group bodies include clinical commissioning groups, NHS trusts, NHS foundation trusts and arm's length bodies.

The GAM is approved by the HM Treasury Financial Reporting Advisory Board.

Accounting policies

Accounting policies for pensions and other retirement benefits are set out in a note to the full accounts (note 1.8) and details of senior employees' remuneration are given in the Remuneration Report.

Charitable funds

Torbay and South Devon NHS Charitable Fund is a registered charity (number 1052232) and as such a separate legal entity, established to hold charitable donations given to Torbay and South Devon NHS Foundation Trust. Donations are received from individuals and organisations and are independent of the monies provided by the government.

The COVID-19 pandemic has had a significant impact upon charitable giving. Since the start of the pandemic, we have been fortunate to receive £51,000 of donations directly from the general public and a further £186,000 from NHS Charities Together, the organisation which has collected and distributed COVID-19 donations made to the NHS as a whole. Further donations are due to be received in future years.

These generous donations have been used primarily to invest in facilities which will improve staff morale and enable staff to work more effectively over the long term, as well as improving the experience of patients.

Based upon the most up to date figures (subject to audit), in 2021/22 the Charitable Fund received donations and legacies totalling £337,000. In addition to 2021/22 COVID-19 funding of £6,000, this included very generous donations of £102,000 from the Leagues of Friends of our hospitals towards the purchase of equipment and other items. The Charitable Fund also received £94,000 from Torbay Medical Research Fund in respect of various research projects.

Other donations have been used to purchase numerous items of medical and other equipment, as well as supporting the training and development of staff and patient/client welfare. Full details can be found in the Charitable Fund's Annual Report and Accounts, which we produce in our role as Corporate Trustee.

Emergency Preparedness, Resilience and Response (EPRR)

On 24 November 2021, our Board of Directors received and signed off the outcome of the NHS England / CCG EPRR core standards assessment for 2021 in relation to

our responsibilities as a Category 1 responder under the Civil Contingencies Act (2004). Assurance was provided to the Board that we had scored: 36 fully compliant, eight partially compliant and two non-compliant therefore making us overall partially compliant focusing on governance arrangements and duty to maintain plans. An action plan has been developed to ensure that we become fully compliant.

During the year we began the process to review and amend our EPRR policy and our incident response plan and we expect them to be finalised and approved in 2022/23.

In addition to the assessment against core standards, we provided assurance to NHSEI and Devon CCG that:

- any organisational changes that have impacted our state of preparedness and assurance have been incorporated into plans
- internal debrief has been undertaken and an overview of key lessons identified and actions taken following the debrief
- lessons identified relevant to winter preparedness have been incorporated into our winter planning for 2022/2023.

Environmental matters and the impact on the environment

We recognise that climate change is a risk to health at both the national and global level. As a provider of healthcare and as a publicly-funded organisation, we are committed to ensuring the long-term sustainability of the natural environment in order to deliver sustainable healthcare and to safeguard human health.

In 2020, NHS England published a report entitled *Delivering a Net Zero National Health Service* which outlines their commitment to respond to the health emergency that arises from climate change.

NHS England has defined two clear targets, which we are aligned to and are:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (the NHS Carbon Footprint Plus)), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

At our October 2021 Trust Board, we approved the nomination of Dave Stacey, Deputy Chief Executive Officer as our Senior Responsible Officer for net zero carbon targets.

During this year we developed our Green Plan which is a key enabling plan for our strategy and vision of better health and care for all. To support us to deliver our Green Plan and our net zero carbon ambition, we have formed a sustainability and wellbeing group which is chaired by our Director of Environment. Membership of the group includes representation from local authority partners as well as key colleagues from across our organisation. Our Green Plan was formally approved at the February 2022 Trust Board, and will form part of a broader Devon ICS Green Plan.

Our Green Plan defines our commitment to environmental sustainability with a primary focus on how we will drive towards the NHS net zero targets. The key outcomes include:

- ensuring we are aligned to the NHS-wide ambition, and that of the Devon Integrated Care System to become the world's first healthcare system to reach net zero carbon emission
- prioritising interventions which improve the quality of healthcare we deliver, while also tackling greenhouse gas emissions and broader sustainability challenges
- defining our strategic approach in such a way that we make the right sustainability decisions first time.

While our Green Plan focuses on 2022-2025, we will ensure it is updated and expanded regularly as and when there is a better understanding of our environmental impacts and how to reduce them. Our Green Plan is aligned with actions and timescales that *Delivering a Net Zero National Health Service* sets out, including the targets for the next 20+ years.

Our Green Plan summarises both where we currently are on our sustainability journey and where we aim to get to. As such, it is intended for all of our key stakeholders, including:

- our staff
- our Board of Directors and senior leadership teams
- our Sustainability and Wellbeing Group
- our governors and members
- our patients and the communities we serve
- our partners in Torbay and South Devon including local authorities, voluntary, community and social enterprise organisations, housing and education.

Through our Green Plan, we are focusing on the following areas to achieve net zero carbon:

- how we manage our existing buildings in the context of energy use and decarbonisation
- how we build new buildings that are net zero carbon in their construction and operation
- how we manage our consumption of water
- how we manage our waste streams
- how we support and develop sustainable travel and transport for patients, staff and visitors, encouraging sustainable travel modes where appropriate
- how we manage the reduction of our carbon footprint relating to anaesthetic gases and other pharmaceutical products
- how we innovate to provide net zero carbon healthcare embracing new working practices and digital enablers
- how we work with our supply chain to reduce, minimise and eventually decarbonise

- how we encourage and develop biodiversity across our green spaces for the benefit of patients, staff and visitors
- how we adapt to ensure we meet the challenges that will arise from climate change.

Our achievements this year include:

- we have replaced old energy inefficient lighting with LED lighting, saving circa 290 tonnes CO_2 and £140,000 per annum on completion
- we have secured grant funding for the development of a Heat Decarbonisation Plan (HDP) that will provide a route-map to decarbonising our buildings currently heated with fossil fuel combustion (HDP completes March 2022)
- we have recently introduced digital technology to enable the assessment and benchmarking of staff commuting patterns and emissions. This will include a scoping analysis to achieve ACEL (Average Commuter Emissions Level). Through this data analysis, we will identify further travel options that will include optimised car sharing for staff via a digital platform and information to support improved public transport options to our various locations of care (and work).
- we continue to work with Torbay Council on a collaborative opportunity to develop a photovoltaic farm that could produce up to 3.2MW of energy that would directly provide power to Torbay hospital potentially saving circa 740 tonnes CO_2 per annum.

Social and community issues

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

We recognise we have a particular responsibility to help our children and young people start well in life, giving them a good foundation of health and wellbeing that will protect them against later ill-health, while also supporting their education, training and future job prospects.

We are working with our community partners to reduce the inequalities experienced by local people. We recognise the impact on employment on long term health outcomes and are committed to providing meaningful, flexible employment for local people as well as work experience and volunteering opportunities. We also recognise the impact of housing, education, environment, debt and many other factors on people's health and wellbeing and will continue to work closely with our communities and in partnership with others to do our bit in making life better for all.

In addition, our staff support many health-related groups in both a business and voluntary capacity. We support and enable our staff to play a full part in the community, for example by acting as governors for schools and colleges.

Anti-bribery and human rights issues

Our internal processes ensure consistency with our zero-tolerance approach to bribery and we work closely with our Local Counter Fraud Specialist (LCFS) to raise awareness of our policies and procedures through local induction sessions and bespoke training. We have continued to use the management database system to support our compliance with NHSEI guidance on managing conflicts of interest. have continued to run awareness campaigns to remind staff of the requirement to comply with NHSEI guidance and the Bribery Act 2010.

We encourage anyone with a concern to speak out and report concerns through our governance processes and our policies and procedures. Employees can raise concerns through internal channels, either via the Freedom to Speak Up Guardians (FTSU) or the LCFS. The FTSU and LCFS report regularly to the Board and the Audit Committee, respectively and the FTSU line management is direct to the Chief Executive. The FTSU Guardian has a standing invitation to the Board Sub-Committee with responsibility for workforce, staffing and wellbeing – the People Committee - and is a regular attendee.

As an organisation we recognise the benefits of ethical procurement and professional training. We endorse membership of the Chartered Institute of Procurement and Supply for our professional buying team. This includes the adoption of the Institute's code of conduct, which is also included within our Standing Orders and Standards of Business Conduct. We encourage best practice within our supply chain by ensuring we are compliant with legislation. We also encourage our suppliers and contractors working on our behalf to challenge unethical behaviour and promote a 'speak up' culture.

We have a number of policies in place which cover social, community, counter fraud, bribery and human rights matters. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients and staff.

We have a Board approved anti-slavery and human trafficking statement, which is published on our website. We are playing a leading role in the development of a Devon and Torbay modern slavery adult victims referral pathway protocol and the formulation of the memorandum of understanding between statutory agencies within the anti-slavery partnership.

Important events since the end of the financial year

There are no important events since the end of the financial year to report.

Liz Davenport, Chief Executive
21 June 2022

Part II – Accountability report

Directors' report

The Directors are responsible for the preparation of the financial statements in accordance with Department of Health and Social Care Group Accounting Manual and that the account gives a true and fair view. The Directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance, business model and strategy.

The Foundation Trust Board of Directors

Our Board of Directors ('the Board') has collective responsibility for the exercise of all our powers. The general duty of the Board and of each Director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for the members of the organisation and for the public. Directors are jointly and severally responsible for all the decisions of the Board.

The Board of an NHS Foundation Trust is accountable for the stewardship of the organisation, our services, resources, staff, and assets. The arrangements established by a Board must be compliant with the legal and regulatory framework, protect and serve the interests of stakeholders, specify standards of quality and performance, support the achievement of organisational objectives, monitor performance, and ensure an appropriate system of risk management and internal control.

Our constitution specifies that the Board of Directors shall comprise:

- a Non-Executive Chairman
- not less than five and no greater than eight other Non-Executive Directors
- a Chief Executive and not less than four and no more than seven Executive Directors
- at least half of the Board, excluding the Chairman, are Non-Executive Directors.

To ensure the balance and effectiveness of the Board, our constitution further requires that:

- one of the Executive Directors shall be the Chief Executive
- the Chief Executive shall be the Accounting Officer
- one of the Executive Directors shall be the Chief Finance Officer
- one of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
- one of the Executive Directors shall be a registered nurse or a registered midwife
- the Board of Directors shall always be constituted so that the number of Non-Executive Directors (excluding the Chairman) equals or exceeds the number of Executive Directors.

Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted.

The Board is accountable to stakeholders for discharging its general duties and is responsible for organising and directing the affairs of our organisation and our services in a manner that will promote success and is consistent with good corporate governance practice, and, for ensuring that in carrying out our duties, we meet our legal and regulatory requirements. In doing so, the Board of Directors ensures that our organisation maintains compliance with its terms of authorisation and other statutory obligations.

The Board reserves some responsibilities to itself, delegating others to the Chief Executive and other Executive Directors or Committees of Directors. Those matters reserved to the Board are set out as a formal schedule which includes approval of:

- our long-term objectives and financial strategy
- annual operating and capital budgets
- changes to our senior management structure
- the Board's overall 'risk appetite'
- our financial results and any significant changes to accounting practices or policies
- changes to our capital and estate structure
- conducting an annual review of the effectiveness of internal control arrangements.

Our Board of Directors delegates responsibility to the Chief Executive to:

- enact the strategic direction of the Board of Directors
- manage risk
- achieve organisational compliance with the legal and regulatory framework
- achieve organisational objectives
- achieve specified standards of quality and performance
- operate within, generate, and capture evidence of the system of internal control.

Board of Directors – disqualification

The following may not become or continue as a member of our Board of Directors:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged
- a person who has made a composition or arrangement with, or granted a Foundation Trust deed for his creditors and who has not been discharged in respect of it
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him
- a person who falls within the further grounds for disqualification as described in our constitution.

Composition of the Board of Directors

Our Board of Directors as at 31 March 2022 is shown below:

Non-Executive Directors	Executive Directors
Richard Ibbotson – Chairman Sally Taylor – Non-Executive Director and Vice Chair Jacqui Lyttle – Non-Executive Director and Senior Independent Director Chris Balch – Non-Executive Director Vikki Matthews – Non-Executive Director Paul Richards – Non-Executive Director Robin Sutton – Non-Executive Director	Liz Davenport – Chief Executive David Stacey – Deputy Chief Executive and Chief Finance Officer Ian Currie – Medical Director Judy Falcão – Chief People Officer John Harrison – Chief Operating Officer Adel Jones – Director of Transformation and Partnerships Deborah Kelly – Chief Nurse

Our Board has an additional non-voting director – Dr Joanne Watson, Health and Care Strategy Director.

Since the year-end there have been no changes in Board membership.

The gender balance of the Board as at 31 March 2022 was:

	Female	Male
Non-Executive Directors	3	4
Executive Directors	4	3

Biographies of the members of the Board are provided in Appendix A.

Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests which may conflict with their role and management responsibilities at our organisation. At each meeting of the Board of Directors, a standing agenda item also requires all Executive Directors and Non-Executive Directors to make known any interest in relation to the agenda and any changes to their declared interests. There are no interests which may conflict with their management responsibilities as per the requirements of the NHS Foundation Trust Code of Governance. The Chairman has no other significant commitments that affect his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

The Chief Executive's Office maintains a register of interests, and is available on our website or by contacting the Trust Secretary at the address given in Appendix B – Further information and contact details.

No political donations were made or received by the organisation in the reporting period.

Independence of the Non-Executive Directors

Our Board of Directors has assessed the independence of the Non-Executive Directors and considers all current Non-Executive Directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement as evidenced through their declarations of interest, previous employment, or tenure.

Committees of the Board of Directors

The Board has established the 'statutory' Committees required by the NHS Act 2006 and our constitution. The Non-Executive Nominations and Remuneration Committee and the Audit Committee each discharge the duties set out in our constitution and their terms of reference.

The Board has chosen to deploy additional 'designated' Committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and financial risk management. These are the Quality Assurance Committee, the Finance, Performance, Digital Committee, the People Committee and the Building a Brighter Future Committee.

The role, functions and summary activities of the Board's Committees are described below:

(a) Non-Executive Nominations and Remuneration Committee

The purpose of the Non-Executive Nominations and Remuneration Committee is to conduct the formal appointment to, and removal from office, of Executive Directors, other than the Chief Executive who shall be appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors. The Committee also considers succession planning for Executive Directors, considering the challenges and opportunities facing the organisation, and the skills and expertise that will be needed on the Board of Directors in the future.

We are also required to appoint a Remuneration Committee in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the Constitution, and the NHS Foundation Trust Code of Governance.

The Non-Executive Nominations and Remuneration Committee fulfils the dual purpose of the two statutory Committees for nomination and remuneration of Executive Directors. It also decides the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and reviews the suitability of structures of remuneration for other senior managers.

The Committee met on 11 occasions in the reporting period for the purpose of considering changes in remuneration for Executive Directors and other senior managers, receiving reports on the appraisals and objective setting for Executive Directors, Executive succession planning, and to lead on the appointments of Executive Directors, namely the Director of Corporate Governance and Trust Secretary. The Committee was supported in the recruitment process by an external recruitment consultant. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any matters requiring disclosure to the Board.

(b) Audit Committee

The Audit Committee works in parallel with the Board's Sub-Committees.

The terms of reference for the Audit Committee are published on the Trust's website. The Audit Committee reviews the effectiveness of systems of governance, risk management and internal control across the whole of the organisation's activities. In comparison, the Quality Assurance Committee reviews the actions being taken by the organisation to ensure the ongoing maintenance of standards of quality of care and improvements, where necessary, to patient experience.

During the year the Audit Committee reviewed the adequacy of:

- all risk and control-related disclosure statements, together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- underlying assurance processes that indicated the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority
- the Committee's terms of reference and work plan.

The Committee sought reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness; notably, the Committee-initiated improvements to the Board assurance framework.

As part of the year-end reporting process, the Chief Finance Officer presented a summary of the financial results, an overview of the financial statements and the key areas of judgment and estimation, building on the external audit risk assessment. The committee also received an update on the implementation of IFRS 16.

The Committee met on five occasions in the reporting period, and was attended by the Chief Finance Officer and other senior managers, including the Deputy Director of Finance, Chief Nurse and Director of Corporate Governance. A governor observer was also in attendance. Representatives from the external auditor (Grant Thornton), internal auditor (ASW Assurance) and our local counter fraud specialist attended each meeting. The Committee undertook a self-assessment during the year and also reviewed its terms of reference. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

The external auditor (Grant Thornton LLP) has not provided any additional non-audit services during the period.

Audit Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accounting Officer for the Foundation Trust, the Audit Committee has examined the adequacy of systems of governance, risk management and internal control within the organisation, from information supplied, and formed the opinion that:

- there is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk
- assurances received are sufficiently accurate, reliable, and comprehensive to meet the Accounting Officer's needs and to provide reasonable assurance
- governance, risk management and internal control arrangements within the organisation include aspects of excellence as well as aspects in which ongoing attention to the control improvement is required
- financial controls are sufficient to provide reasonable assurance against material misstatement or loss
- the quality of both internal audit and external audit over the past year has met all the organisation's requirements.

The Committee discharged its role through the year as follows:

- we reviewed the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical);
- we ensured that there was an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee. The Committee reviewed and approved the internal audit plan, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. The audit plan was reviewed during the year to ensure it remained risk based.
- we considered the major findings of internal audit's work (and management's response). The internal auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The key audit matters related to: ISA 240 revenue risk, valuation of land and buildings, management over-ride of controls, completeness of expenditure risk and, financial sustainability in respect of the organisation's arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the Annual Report and financial statements before submission to the Board
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made

- we reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the organisation.

(c) Quality Assurance Committee

The Board of Directors has established the Quality Assurance Committee to support the Board in discharging its responsibilities for monitoring the quality of the organisation's services. This includes the essential standards of quality (as determined by Care Quality Commission's registration requirements), and national targets and indicators (as determined by NHSEI's Oversight Framework). The Committee's work plan is aligned to the organisation's corporate objectives and associated risks.

The Committee reviews the outcomes associated with clinical services and patient experience and, the suitability and implementation of risk mitigation plans regarding their potential impact on patient outcomes. The Committee is also required, as directed by the Board from time to time, to consider issues relating to quality where the Board requires this additional level of scrutiny.

During the year, the Committee considered:

- the Board assurance framework and corporate level risks
- operational and strategic risks relating to COVID-19
- data and quality and safety metrics in relation to never events, long stay patients with mental health and domiciliary care, Venous thromboembolism (VTE), stroke, maternity and serious incidents
- quality and safety risks in relation to operational matters and harm reviews
- clinical governance framework and associated priorities
- patient safety strategy
- progress against the Care Quality Commission improvement plan
- internal audit reports relating to patient safety and quality
- patient surveys that also included reports on patient experience
- the integrated quality, finance, and performance report from a quality and safety perspective.

A programme of service reviews during the year was introduced during the year enabling the Committee to undertake a detailed deep-dive in to specific services or specialties. To date the Committee has conducted deep-dives into the stroke and ophthalmology services, safety framework for 12-hour breaches, autism spectrum disorder diagnostic pathway, social care placement quality assurance and quality assurance framework for independent providers.

The Committee met six times during this reporting period. Along with Committee members, the Committee was attended by a number of senior managers, including System Directors of Nursing and Professional Practice, Clinical Service Leads and the Director of Corporate Governance. The Chief Executive and Audit Committee Chair attended on occasions in an observer capacity. A governor observer was also present at the majority of meetings. The Chair of the Committee submitted a report

to the Board following each meeting, highlighting any issues requiring escalation to the Board.

(d) Finance, Performance, and Digital Committee

The Finance, Performance, and Digital Committee has delegated authority from the Board of Directors, subject to any limitations imposed by the schedule of matters reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- control and management of the finances of the organisation
- target level of efficiency savings and actions to ensure these are achieved
- budget setting principles
- year-end forecasting
- commissioning
- capital planning.

The Finance, Performance, and Digital Committee met on twelve occasions during this reporting period. The Chief Executive and Audit Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend each meeting and was present at the majority of meetings. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

(e) People Committee

The purpose of the People Committee is to provide assurance to the Board on the following:

- national workforce guidance and strategies
- the people plan and associated activity/implementation plan(s) to support our forward strategy;
- key people and workforce performance metrics and targets
- provide assurance on those elements of the Board assurance framework identified as the responsibility of the Committee
- effectiveness of staff communication and levels of staff engagement
- strategic people and workforce issues at national and local level
- act as an early point of contact for the FTSU Guardian to raise concerns prior to reporting to Board.

During the year, the Committee has considered:

- review of the Board assurance framework and corporate risk register, with appropriate challenge to the proposed controls and risk scoring;
- deep-dives in to the achievement reviews, just and learning culture, attraction and retention of talents and our response to COVID-19 from the staffing perspective.
- received reports on progress against our people plan and promise
- received assurance reports around education and workforce development
- reviewed the workforce information including pay and absence information
- reviewed talent management and succession planning arrangements

- received reports on the Workforce Transformation Programmes
- triangulated information to reconcile headcount and finance data.

The People Committee meets on a bi-monthly basis and is chaired by a Non-Executive Director. The Committee membership also includes two further Non-Executive Directors, Chief People Officer, Chief Operating Officer, the Chief Nurse and the Medical Director. The Chief Executive and Audit Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

(f) Building a Brighter Future Committee

The Building a Brighter Future Committee was established for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme 'Building a Brighter Future' and to support the successful achievement of the programme investment objectives and realisation of the stated benefits. The Committee also provides assurance around the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirms that projects are delivering the stated benefits, are value for money, and are ultimately affordable.

The Building a Brighter Future Committee meets on a monthly basis and is chaired by a Non-Executive Director. The Committee also comprises two further Non-Executive Directors, Medical Director, Chief Finance Officer and the Senior Responsible Officer/ Programme Sponsor. The Chief Executive and Audit Committee Chair attended on occasions in an observer capacity. A governor observer was invited to attend and was present at each meeting.

Enhanced quality governance reporting

The Board was satisfied during the year that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information), the organisation had, and will keep in place, effective leadership arrangements for monitoring and continually improving the quality of health and social care, including:

- ensuring required standards are achieved (internal and external)
- investigating and acting on substandard performance
- planning and managing continuous improvement
- identifying, sharing, and ensuring delivery of best-practice
- identifying and managing risks to quality of care.

This encompasses an assurance that due consideration was given to the quality implications of plans (including service redesigns, service developments and cost improvement plans), in the form of quality and equality impact assessments, and that processes are in place to monitor their ongoing impact on quality and take subsequent action, as necessary, to ensure quality is maintained.

The basis of the Board of Directors confirmation was set out in the draft corporate governance statement to be submitted to NHSEI. The Annual Governance Statement provides further information.

Membership and attendance at Board and Committee meetings

The Board of Directors discharged its duties during 2021/22 in ten meetings, and through the work of its Committees. The Chairman of the Board submitted a report to the Council of Governors (CoG) at each meeting, highlighting any matters requiring disclosure to the Council.

The table below shows the membership and attendance of directors at meetings of the Board and Board Committees during the year.

Figures in brackets indicate the number of meetings the individual could be expected to attend by their membership of the Board or Committee. A dash indicates that the individual was not a member. ‘C’ denotes the Chair of the Board or Committee.

2021-22	Board of Directors	Council of Governors	Non-Executive Director Nominations and Remuneration Committee	Audit Committee	Quality Assurance Committee	Finance, Performance, and Digital Committee	People Committee	Building a Brighter Future Committee
Number of meetings	10	4	10	5	6	13	6	12
Richard Ibbotson	C10(10)	C4(4)	C10(10)	-	-	-	-	-
Liz Davenport	10(10)	5(6)	10(10)	-	-	-	-	-
Chris Balch	10(10)	4(4)	-	4(5)	-	13(13)	6(6)	12(12)
Jacqui Lyttle	8(10)	4(4)	10(10)	5(5)	6(6)	-	-	-
Vikki Matthews	6(10)	2(4)	5(10)	4(5)	6(6)	-	5(6)	-
Paul Richards	10(10)	4(4)	-	5(5)	-	13(13)	-	12(12)
Robin Sutton	8(10)	3(4)	-	-	-	11(13)	-	-
John Welch*	4(5)	2(2)	-	-	1(3)	-	2(3)	4(6)
Sarah Wollaston**	2(3)	1(2)	-	-	0(1)	-	1(1)	0(2)
Sally Taylor	10(10)	4(4)	10(10)	5(5)	-	-	-	-
Judy Falcão	6(10)	3(4)	-	-	3(6)	-	5(6)	-
John Harrison	6(10)	3(4)	-	-	5(6)	8(13)	2(6)	-
Adel Jones	9(10)	3(4)	-	-	-	12(13)	-	8(9)
Deborah Kelly	9(10)	2(4)	-	3(5)	6(6)	8(13)	4(6)	-
David Stacey	9(10)	1(4)	-	5(5)	-	13(13)	-	10(12)
Ian Currie	8(10)	4(4)	-	-	4(6)	11(13)	2(2)	8(12)
Rob Dyer***	3(3)	1(1)	-	-	-	-	-	2(3)

*Left the organisation on 30.09.21

**From 01.10.21 to 29.11.21

***Left the organisation on 05.07.21

Performance of the Board and Board Committees

Members of the Board are subject to on-going and regular performance appraisal. The Chief Executive appraises individual Executive Directors. Non-Executive Directors and the Chief Executive are appraised by the Chairman. The Chairman was appraised by the Senior Independent Director for 2021/22 in accordance with the new guidance issued by NHSEI '*Framework for conducting annual appraisals of NHS provider chairs'*.

The outcome of these appraisal processes was presented to the governors' Nominations and Appointments Committee and confirmed with the Council of Governors. Confirmation of the process undertaken in respect of the Chairman's appraisal has been submitted to the NHSEI Regional Director, Chair and Chief Operating Officer in accordance with the aforementioned guidance.

The Board of Directors undertakes a regular self-assessment of its performance to establish whether it has adequately and effectively discharged its role, functions, and duties.

For the reporting period, the Board's performance, considering the role, function, and work of the Board Committees, was of the requisite standard. The Board believes that it is balanced and complete in its composition and appropriate to the requirements of the organisation. This was attributed to the comprehensive annual cycle of reporting, a robust Board assurance framework and risk register, and a development plan undertaken under the guidance of the Chair and Trust Secretary.

The findings of the internal audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusion.

Similar assessment exercises were undertaken for each of the Committees of the Board, all of which were considered to have fully discharged the duties set out in their terms of reference.

The Council of Governors

The Council of Governors is responsible for discharging the general duties set out in legislation which are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the organisation as a whole and the interests of the public.

The Council of Governors discharged its statutory duties as set in the NHS Code of Governance supported through its sub-committees and working groups. However, a concern has been expressed about insufficient interactions between governors, Non-Executive Directors and the senior management due to lack of face-to-face meetings because of the COVID-19 pandemic in the past two years. Following the relaxation of the rules on COVID-19, steps are being taken to return to face-to-face meetings in order to address this concern.

It remains the responsibility of the Board of Directors to design and implement the organisational strategy. The Council of Governors and the Board of Directors communicate principally through the Chairman who is the formal conduit and Chairman of the two bodies. This relationship is formally extended and augmented by governors and directors' participation in Board to Council meetings to ensure constant and clear communication and co-operation between the Board and the Council of Governors. Additionally, directors regularly attend meetings of the Council of Governors. During the reporting year, meetings in person have not taken place and therefore attendance has taken place virtually via MS Teams.

The Board of Directors may request the Chairman to seek the views of the Council of Governors on any matters it may determine. Communications and consultations between the Council of Governors and the Board include, but are not limited to the following topics:

- our annual plan
- the Board's strategic proposals
- clinical and service priorities
- proposals for new capital developments
- engagement of our membership and the public.

The Board of Directors presents the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors.

Membership and attendance at Council of Governors' meetings

The table below shows the membership and attendance of governors at meetings of the Council of Governors during the year. Figures in brackets indicate the number of meetings the individual could be expected to attend by their membership of the Council of Governors.

Public constituencies			
Name	**Constituency**	**Tenure**	**CoG Attendance**
Craig Davidson	South Hams and Plymouth	Re-elected – 01 March 2022	1(4)
Mary Lewis	South Hams and Plymouth	Re-elected – 01 March 2019 Term ended – 28 February 2022	2(3)
Jonathan Shribman	South Hams and Plymouth	Elected – 01 March 2020	2(3)
Dave Cawley	South Hams and Plymouth	Elected – 01 March 2022	1(1)
Carol Day	Teignbridge	Re-elected – 08 March 2019 Term ended – 28 February 2022	3(3)
Janette Goodman	Teignbridge	Elected – 01 March 2022	0(1)
Eileen Engelmann*	Teignbridge	Re-elected – 01 March 2022	4(4)
Annie Hall	Teignbridge	Re-elected – 01 March 2022	3(4)
Michael James	Teignbridge	Re-elected – 01 March 2022	1(4)
John Smith*	Teignbridge	Re-elected – 01 March 2022	4(4)
Jean Thomas	Teignbridge	Elected – 01 March 2021	4(4)
Loveday Densham	Torbay	Elected – 01 March 2021	4(4)
Steven Harden	Torbay	Re-elected – 01 March 2020	2(4)
Lynne Hookings	Torbay	Re-elected – 08 March 2019 Term ended – 28 February 2022	3(4)
Febuary Howson	Torbay	Elected – 01 March 2021 Removed – 03 November 2021	0(3)
John Kiddey	Torbay	Elected – 01 March 2020	4(4)
Andrew Stilliard	Torbay	Elected – 01 March 2020	4(4)
Keith Yelland	Torbay	Elected – 01 March 2021	3(4)
Peter Milford	Torbay	Elected – 01 March 2022	1(1)
Mark Tyrrell-Smith	Torbay	Elected – 01 March 2021 Resigned – 10 June 2021 (Moved out of Teignbridge constituency) Re-elected – 01 March 2022	2(2)

*Appointed 03 Feb 2021: Lead Governor, John Smith / Deputy Lead Governor, Eileen Engelmann

Staff-elected governors (staff constituency), six representatives (two vacancies)			
Name	**Class**	**Tenure**	**CoG Attendance**
Matthew Arthur	Paignton and Brixham ISU	Elected – 01 March 2021	2(4)
Emily Huggins	Trustwide Operations and Corporate Services ISU	Elected – 01 March 2021	2(4)
Deborrah Kelly	Torquay ISU	Elected – 01 March 2021	1(4)
Radia Woodbridge	Moor to Sea ISU	Elected – 01 March 2021	3(4)
Vacancy	Newton Abbot ISU		
Vacancy	Coastal ISU		

Appointed governors (partner organisations)			
Name	**Organisation**	**Tenure**	**CoG Attendance**
Derek Blackford	Devon CCG	Re-appointed – 01 April 2020	4(4)
Jonathan Hawkins	Devon County Council	Appointed – 14 May 2019	0(4)
Lorraine Evans	Teignbridge District Council	Appointed – 18 June 2019	0(4)
Nicole Amil	Torbay Council	Re-appointed – 01 October 2020	4(4)
Rosemary Rowe	South Hams District Council	Appointed – 25 July 2019	2(4)

Governor elections

In order to refresh the Council of Governors and bring a diverse range of views in to our organisation, elections are held every year. These elections are held in the various geographical or staff constituencies as set out in our constitution. During this year, the following elections were held with each member being offered a three-year term of office.

Constituency	Candidate	Result	Voting %
Torbay	Mark Tyrrell-Smith	Elected	18.7%
Torbay	Peter Milford	Elected	
Teignbridge	Eileen Englemann	Elected unopposed	Not applicable
Teignbridge	Janette Goodman	Elected unopposed	Not applicable
Teignbridge	Annie Hall	Elected unopposed	Not applicable
Teignbridge	Michael James	Elected unopposed	Not applicable
Teignbridge	John Smith	Elected unopposed	Not applicable
South Hams & Plymouth	Dave Cawley	Elected	19.7%
South Hams & Plymouth	Craig Davidson	Elected	

Governors' interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as governors. Our membership office maintains a register of interests which is published on our website.

Committees of the Council of Governors

The Council of Governors has appointed one standing Committee and one working group. These are:

(a) Governors' Nomination and Remuneration Committee

The Governors' Nomination and Remuneration Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, our constitution, and the NHS Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to appointments, remuneration and other terms of service of the Chairman and Non-Executive Directors. Its functions include:

- to receive advice as directed by the regulator and determine overall remuneration and terms and conditions of service for the Chairman and Non-Executive Directors
- to recommend to the Council of Governors the levels of remuneration and terms and conditions of service for Chairman and Non-Executive Directors
- to monitor the performance of the Non-Executive Directors through the Chairman
- to monitor the performance of the Chairman through the Senior Independent Director
- to undertake a periodic review of the numbers, structure, and composition (including the person specifications) of the Chairman and Non-Executive

Directors, to reflect the expertise and experience required, and to make recommendations to the Council of Governors
- to develop succession plans for the Chairman and Non-Executive Directors, considering the size and composition of the organisation
- identify and nominate candidates to fill the Chairman and Non-Executive Director posts as they arise.

The Committee met six times during the year to consider remuneration levels for Non-Executive Directors, re-appointment of the Chairman and Non-Executive Directors, determine the process for appraising the performance of the Chairman and Non-Executive Directors and reviewed the succession plan for Non-Executive Directors. In considering the remuneration levels and the performance appraisal process, the Committee took in to account the guidance issued by NHSEI and ensured processes were in line with that guidance. The Committee also undertook a self-assessment of its effectiveness and reviewed its terms of reference.

(c) Membership Committee

The Membership Committee is a formal Committee established in accordance with our constitution for monitoring, maintaining, and advancing the membership. Its primary purpose is:

- advice – by offering advice and information to the Council of Governors on the community perception of our conduct of our healthcare provision
- recruitment – by seeking to maintain the registered membership at its present level and to maintain under review means of achieving a representation of all sectors of the community
- information – by promoting a series of seminars and events for members and members of the public, focusing on significant sectors of our work
- engagement – by promoting communications to and from members.

The Committee continued to meet virtually during 2021/22, using MS Teams. Meeting and in person and face-to-face engagement with members and the public were subject to the restrictions in place during the COVID-19 pandemic. Email and social media were the primary means of communication and engagement in 2021/22.

Membership and meetings of the Council of Governors

Membership is free and aims to give local people and staff a greater influence over how our services are provided and developed. It also helps us to work much more closely with local people and the people who use our services. Our members have the chance to find out more about the hospitals, our community services, the way they are run and the challenges they face, and furthermore, help us work with local people to improve the care and experience of patients and their carers'.

We had 15,421 members as at 31 March 2022, split between 8,721 public members and 6,743 staff members. The public constituencies of South Hams and Plymouth (eastern), Teignbridge and Torbay comprised 1,044 members, 3,178 members, and 4,491 members, respectively. Public membership is open to people aged 14 or over and who live within our defined membership area. During the reporting year, a data cleanse exercise was undertaken which provided members with the opportunity to check and update the details we hold for them. All eligible staff automatically become

staff members unless they choose to opt out. Staff are eligible for membership provided that they hold a permanent contract of employment with us or they have been employed by us on a temporary contract of 12 months or longer.

The Council of Governors met on a total of four occasions during 2021/22. In the reporting period, all Council of Governors meetings have been held virtually, via MS Teams. A virtual Annual Members' Meeting was held at which the Annual Report was presented to the governors by the Board.

The Council of Governors also met virtually with the Board of Directors on two occasions for the purpose of providing input to the organisation's forward strategy and annual plan for 2021/22 and beyond.

Performance of the Council of Governors

The Council of Governors is required to undertake a regular self-assessment of its performance year to establish whether it has adequately and effectively discharged its role, functions, and duties during the preceding year. The Council of Governors' self-assessment exercise for 2021/22 is planned to be done as part of an externally facilitated 3-day workshop.

Stakeholder relations

In addition to our partnership working, we engage directly with other stakeholders including our patients, service users, carers, families, and the public to understand, listen and where possible adapt or change the services we offer and recognise the value of their ideas about these how services can be developed and improved.

Our Board of Directors recognises the importance of understanding the experiences of people who use our services and continues its commitment to receive a story regularly at Board meetings.

With such a large public membership, this allows the organisation to harness and utilise the experience of our members, who provide us with knowledgeable information. Our governors attend our Board sub-committee's as observers and patient representatives also attend important groups such as the patient feedback and engagement group, quality improvement group and mortality surveillance group, so that we can better understand the experiences and needs of people who use our services.

Information and feedback are received from many quarters including national surveys and local surveys. We resumed the Friends and Family Test and aim to resume real time inpatient experience survey soon which is led by our working with us volunteers and supported through clinical effectiveness and consultations. These provide a rich source of data and with the national surveys provide benchmark data we can use for comparisons. We also receive valuable ideas and suggestions from well-established patient pathways, social media and our patient and service user groups.

We also work with external organisations such as Healthwatch and seAp (a charity providing independent and confidential advocacy services), both of which help us hear the voices of people who use our services more clearly. We are committed to

working in partnership to improve how we listen to, and use, people's experiences to improve our services.

The Council of Governors' Membership Committee, focuses on ensuring there is an ongoing dialogue with members and that we continue to develop the membership to make it as representative as possible of the whole community. Public membership at the end of March 2021 totalled 9,589 and 8,721 at the end of March 2022. This represents just under seven per cent of the households in our catchment area. Members of the public, living in any of the three public constituencies and aged over 14, are eligible to become members.

Fees and charges (income generation)

Costs associated with fees and charges levied by the organisation are set out in note 5 to the annual accounts.

Income disclosures required by Section 43(2A) of the NHS Act 2006

As disclosed in the Foundation Trust's annual accounts, the Foundation Trust complies with the need to ensure that income from the provision of goods and services for health services in England is greater than its income from the provision of goods and services for any other purpose; Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).
The other income that the Foundation Trust receives either fully covers the cost of those services or for income generating activities, profit is directly reinvested into the provision of health and social care.

Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement & NHS England.

Better payment code of practice

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

No payments were made during the year (2020/21: £Nil) under the Late Payment of Commercial Debts (Interest) Act 1998.

	2021/22		2020/21	
	Number	**£000**	**Number**	**£000**
Total Non-NHS trade invoices paid in the year	145,108	286,203	126,099	243,447
Total Non-NHS trade invoices paid within target	123,927	240,117	110,457	204,318
Percentage of Non-NHS trade invoices paid within target	**85%**	**84%**	**88%**	**83%**
Total NHS trade invoices paid in the year	2,093	26,773	1,790	25,358
Total NHS trade invoices paid within target	1,229	20,663	1,113	13,086
Percentage of NHS trade invoices paid within target	**59%**	**77%**	**62%**	**52%**

Counter fraud policies and procedures

We have a clear strategy for tackling fraud, corruption and bribery. This is documented in our counter fraud, bribery and corruption policy which details responsibilities and how to report suspicions of fraud, bribery or corruption.

We have a lead accredited LCFS via consortium arrangements with ASW Assurance. In addition, we have a number of nominated support personnel from within the consortium that are able to support the organisation as required. The LCFS ensures risks are mitigated and systems are resilient to fraud, corruption and bribery. An annual counter fraud work plan is reviewed and approved by the Audit Committee.

The Deputy Chief Executive and Chief Finance Officer and the Audit Committee oversee the work of the LCFS. Reports on progress with delivery together with outlines of referrals received and investigations are regularly provided to the Audit Committee. The LCFS also highlights to the Committee any issues that have arisen so that appropriate action can be taken.

The program of counter fraud work was delivered in 2021/2022 addressing all components of the Government Functional Standard GovS 013: Counter Fraud and NHS Counter Fraud Authority strategy. The LCFS develops and maintains key relationships across the organisation and this, coupled with the work undertaken by the LCFS, has resulted in the development of a strong anti-fraud culture.

Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement & NHS England.

Accessible Information Standard

NHS England mandated the Accessible Information Standard (AIS) on 24 June 2015, which applies to all organisations providing NHS or Adult Social Care. Organisations are required to follow the standard by law. The AIS directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting individuals' information and communication support needs. We have assigned an implementation lead and lead director to drive forward work in this important area and we continue to make progress with the help and input of people who use our services.

Statement as to Disclosure to Auditors (s418)

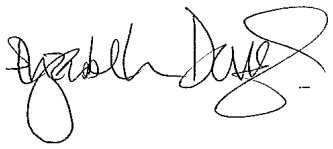
The Board of Directors reports that for everyone who is a director at the time this report is approved:

- as far as the director is aware, there is no relevant audit information of which our auditor is unaware
- the director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that our auditor is aware of that information.

’Relevant audit information’ means information needed by our auditor in connection with preparing their report. A director is regarded as having taken all the steps that they ought to have taken as a director to do the things mentioned above, and:

- made such enquiries of their fellow directors and of the corporation’s auditors for that purpose
- taken such other steps (if any) for that purpose, as are required by their duty as a director of the company to exercise reasonable care, skill, and diligence.

The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the organisation’s performance, business model and strategy.



Liz Davenport, Chief Executive
21 June 2022

Part III – Remuneration Report

Salary and pension entitlements of senior managers as at 31 March 2022 (audited information)

	2020-21						2021-22					
	Salary	**Expense Payments (taxable)**	**Annual Performance Pay and Bonuses**	**Long-term Performance Pay and Bonuses**	**All Pension Related Benefits**	**Total**	**Salary**	**Expense Payments (taxable)**	**Annual Performance Pay and Bonuses**	**Long-term Performance Pay and Bonuses**	**All Pension Related Benefits**	**Total**
Name and Title	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£	£000	£000	£000	£000	£000	£	£000	£000	£000	£000
Mrs L Davenport Chief Executive	205-210	0	0	0	55-57.5	260-265	190-195	0	0	0	60-62.5	250-255
Prof J Viner Chief Nurse and Deputy Chief Executive (to 31st July 2020)	40-45	0	0	0	0	40-45						
Dr R G Dyer Deputy Chief Executive	210-215	0	0	0	232.5-235	440-445	55-60	0	0	0	0	55-60

(retired 5th July 2021)												
Mr I Currie Executive Medical Director	200-205	0	0	0	195-197.5	395-400	210-215	0	0	0	247.5-250	460-465
Ms D Kelly Chief Nurse	80-85	0	0	0	0	80-85	125-130	0	0	0	0	125-130
Mr D Stacey Chief Finance Officer and Deputy Chief Executive	140-145	0	0	0	52.5-55	195-200	150-155	0	0	0	47.5-50	200-205
Ms A Jones Director of Transformation and Partnerships	120-125	0	0	0	62.5-65	185-190	120-125	0	0	0	5.0-7.5	130-135
Mrs J Falcão Director of Workforce and Organisational Development	120-125	0	0	0	35-37.5	155-160	120-125	0	0	0	35-37.5	155-160
Mrs L Darke Director of Estates and Commercial	35-40	0	0	0	0	35-40						

Development (to 31st July 2020)												
Mr J Harrison Chief Operating Officer	120-125	0	0	0	37.5-40	155-160	125-130	0	0	0	55-57.5	180-185
Dr J Watson Health and Care Strategy Director (commenced 1st February 2021)	15-20	0	0	0	0 – 2.5	0	170-175	0	0	0	112.5-115	285-290
Mrs E Long Director of Corporate Governance and Trust Secretary (commenced **1st November 2021)**							35-40	0	0	0	10-12.5	45-50
Mr O Raheem Interim Director of Corporate Governance and Trust Secretary (commenced 15th February 2022)							10-15	0	0	0	7.5-10	20-25
Sir R Ibbotson Chairman	50-55	300	0	0		50-55	50-55	1,000	0	0		50-55

Mrs S Taylor Vice Chair / Non-Executive Director	15-20	~~0~~ 100	0	0		15-20	15-20	0	0	0		15-20
Mrs J Lyttle Non-Executive Director and Senior Independent Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mr J Welch Non-Executive Director (Retired 30 Sept 2021)	10-15	200	0	0		10-15	5-10	0	0	0		5-10
Mr R Sutton Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mr P Richards Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mrs V Matthews Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Prof C Balch	10-15	0	0	0		10-15	10-15	0	0	0		10-15

Non-Executive Director												
Dr S Wollaston Non-Executive Director (commenced **1st October 2021**, left 29th November 2021)							0-5	0	0	0		0-5

Notes:

Dr R G Dyer retired on 5 July 2021.

Mr D Stacey was appointed as Deputy Chief Executive on 5th July 2021 and continues to be the Trust's Chief Finance Officer.

Dr J Watson's remuneration is inclusive of clinical, operational as well as Trust Board duties.

Mrs E Long started was appointed on 1st November 2021 as Director of Corporate Governance and Trust Secretary and remains in post.

Mr O Raheem was appointed on 15th February 2022 as Interim Director of Corporate Governance and Trust Secretary.

Mr J Welch retired 30 September 2021

Dr S Wollaston, was appointed on 1st October 2021 but left the trust 29 November 2021 to take up another NHS appointment.

The following have opted out of the pension scheme: Ms D Kelly before joining the Trust.

The taxable benefits are in respect of travel expenses that are subject to income tax.

None of the Directors received any annual or long-term performance-related benefits.

Page 65 refers to managers who are paid more than £142,500 per annum (not including pension related benefits).

Pension benefits as at 31 March 2022 (audited information)

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2021 £000	Real Increase / (Decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Employers Contribution to Stakeholder Pension (to nearest £100) £000
Mrs L Davenport Chief Executive	2.5-5.0	0.0-2.5	85-90	195-200	1,667	76	1,779	0
Mr I Currie Executive Medical Director	10.0-12.5	25.0-27.5	80-85	230-235	1,691	287	2,013	0
Dr R G Dyer Deputy Chief Executive (retired 5th July 2021)	0	0	75-80	225-230	1,862	0	0 *	0
Mr D Stacey Chief Finance Officer and Deputy Chief Executive	2.5-5.0	0	20-25	0	167	20	202	0
Ms A Jones Director of Transformation and Partnerships	0.0-2.5	**0**	35-40	65-70	559	**4**	582	0

Mrs J Falcão Director of Workforce and Organisational Development	2.5-5.0	0-2.5	50-55	105-110	919	**39**	980	0
Mr J Harrison Chief Operating Officer	2.5-5.0	2.5-5.0	40-45	80-85	690	**55**	764	0
Mrs E Long Director of Corporate Governance and Trust Secretary	0-2.5	0	0-5	0	0	**2**	7	0
Mr O Raheem Interim Director of Corporate Governance and Trust Secretary	0-2.5	0	0-5	0	0	**6**	8	0
Dr J Watson Health and Care Strategy Director	5.0-10	5.0-10	60-65	125-130	1,088	**112**	1,227	0

* Dr R Dyer retired on 5th July 2021. At which point the pension began to be drawn. Accordingly, the CETV of Dr Dyer's pension at 31st March 2022 is not available.

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued because of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005-06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member because of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Annual Statement on Remuneration

There have been no changes to the remuneration policy for senior managers during the year.

For Executive Directors there are no arrangements relating to termination payments other than the application of employment contract law. No termination payments have been made to either present or past senior managers within 2021/22.

The Non-Executive Directors Nomination and Remuneration Committee (the 'Committee'), whose function it is to decide pay for Executive Directors conduct a review of executive salaries each year.

During the year ending 31 March 2022, four senior managers (Chief Executive, Deputy Chief Executive, Medical Director and the Health & Care Strategy Director (including payment for role as a Consultant) were paid more than £142,500. The steps outlined above provides the Non-Executive Nominations and Remuneration Committee with assurance that the remuneration level is reasonable and linked appropriately to the weight of the role based on accountability, job responsibilities and the knowledge and skills required for each of those positions.

Remuneration is set in accordance with NHS Agenda for Change for all staff other than doctors and directors. Pay and conditions of service for doctors is agreed nationally.

Senior managers' remuneration policy

The remuneration package for senior managers consists of the following factors:

Item	Rationale
Salary	Our strategy and business planning process set the key business objectives of our organisation which are delivered by the senior managers. This success measure is one of the ways in which the senior managers' performance is monitored. Senior managers' remuneration is based on market rates and there are no automatic salary rises. To ensure that the pay and terms of service offered by the organisation are both reasonable and competitive, comparisons are made between the scale and scope of responsibilities of our senior managers and those of employees holding similar roles in other organisations. A report is prepared for the Non-Executive Nominations and Remuneration Committee by the Chief People Officer, which makes these comparisons between our remuneration rates for senior managers and market rates. The base salaries of Executive Directors in post at the start of the policy period and who remain in the same role throughout the policy period will not usually be increased by a higher percentage than the maximum incremental uplift applicable to the highest paid staff on Agenda for Change. The only exceptions are where an Executive Director has been appointed at below market level to reflect experience. Senior managers are paid spot level salaries rather than on an incremental scale and may collectively receive an annual uplift in salary in line with '*Guidance on pay for very senior managers'* issued by NHSEI.

	All senior managers' remuneration is subject to satisfactory performance of duties in line with their employment. There are no performance related pay so senior managers receive one hundred per cent of their salary subject to the relevant deductions.
Taxable benefits	The Non-Executive Nominations and Remuneration Committee agree any taxable benefit. This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive. There is no maximum amount payable.
Pension	Standard pension arrangements are in place in 2021/22. This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive. There is no maximum amount payable.
Bonus	There is no bonus scheme for any senior manager, however bonus payments may be made on a discretionary basis subject to approval by the Non-Executive Nominations and Remuneration Committee. All other staff, except the senior management team at Torbay Pharmaceuticals, are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.
Other	Individual items such as lease cars are not offered as part of a remuneration package. Board level directors may, however, put forward an individual request in respect of such items. Senior managers' terms and conditions e.g. holidays, pensions, sick pay are in accordance with Agenda for Change terms and conditions.

Senior manager's objectives and performance

Senior managers meet annually with the Chief Executive to agree core and individual performance objectives and subsequently meet with the Chief Executive monthly to discuss the progress made towards the targets set. A formal interim progress review is held six months after the objectives are set, a final review of performance and achievement of objectives is held at the end of the year, when objectives for the following year are also discussed and agreed.

The Chief Executive's performance is appraised using the same system, but their performance objectives are agreed with and monitored by the Chairman. This process was designed to ensure that clearly defined and measurable performance objectives are agreed, and progress towards these objectives is regularly and openly monitored, both formally and informally.

The Chief Executive presents an assurance report to the Committee each year outlining the appraisal process undertaken. The Committee also receives a summary

report on the performance of each of the Executive Directors and Associate Directors and a recommendation in respect of any proposed changes to remuneration levels. The Chairman adheres to the same process in regard to the Chief Executive.

Remuneration of Executive Directors and other employees

When setting remuneration levels for the Executive Directors, the Nominations and Remuneration Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other Foundation Trusts of a similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader organisational workforce.

In particular, the Nominations and Remuneration Committee considers the recommendations of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration as reflecting most closely the economic environment encountered by Executive Directors. We do not consult more widely with employees on such senior managers' remuneration matters.

Annual Report on remuneration

Service contracts: The following table shows for each person who was an Executive or Associate Director or Non-Executive Director as at 31 March 2022, the commencement date for their current position and the term of service agreement or contract for services and details of notice periods.

Director	Contract start date	Contract term (years)	Unexpired term at the date of publication^	Notice period by the organisation	Notice period by the director
Mr I Currie	14.09.2020	Indefinite terms	Not applicable	Three months	Three months
Ms L Davenport	01.10.2018	Indefinite term	Not applicable	*	Six months
Ms J Falcão	01.08.2016	Indefinite term	Not applicable	*	Six months
Mr J Harrison	01.04.2019	Indefinite term	Not applicable	Three months	Three months
Mrs A Jones	22.07.2019	Indefinite term	Not applicable	Three months	Three months
Ms D Kelly	01.08.2020	Indefinite term	Not applicable	Three months	Three months
Mr D Stacey	06.01.2019	Indefinite term	Not applicable	Three months	Three months
Dr J Watson	01.02.2020	Indefinite term	Not applicable	Three months	Three months
Mrs E Long	01.11.2021	Indefinite term	Not applicable	Three months|	Three months

Mr O Raheem	15.02.22	1 year	7 months	Three months	Three months
Sir Richard Ibbotson	01.06.2021	1 year**	11 months	three months	Three months
Mr C Balch	14.04.2022	3 years***	2 years and 8 months	Three months	Three months
Mrs J Lyttle	30.09.2020	1 year**	1 year and 2 months	Three months	Three months
Mrs V Matthews	01.12.2020	3 years***	1 year and 4 months	Three months	Three months
Mr P Richards	13.11.2020	3 years***	1 year and 5 months	Three months	Three months
Mr R Sutton	01.05.2022	1 year **	9 months	Three months	Three months
Mrs S Taylor	01.01.2022	6 mths****	5 months	Three months	Three months

Notes:
*as per statutory notice period i.e. one week for each year of employment up to a maximum of 12 weeks
**Sir Richard Ibbotson and Mrs J Lyttle re-appointed for a two one-year term following two terms of office of three years.
***Non-Executive Directors re-appointed for a second term of office of three years
****Non-Executive Director tenure extended for two 6-months period.
^date of publication taken to mean July 2022.

Unless noted above, these officers have been in post throughout 2021/22.

Service contracts

As described above, senior managers contracts are open-ended (permanent) contracts. Non-Executive Directors serve terms of three years, up to a maximum of six years. The Council of Governors will consider and set terms of office for Non-Executive Directors beyond that point that meet the needs of the organisation, taking into account NHSEI guidance and the NHS Code of Governance. Terms beyond that point should be set on an annual basis. Further details about the terms of office of each individual Non-Executive Director can be found in the Director's report within this annual report and accounts.

Remuneration Committee Memberships and Meetings

Membership and details of meetings attendance can be found at page 45 of this report.

We have established two Committees responsible for the remuneration, appointments and nominations of directors. A description of the Committee responsible for Non-Executive Director remuneration can be found in the section 'Committees of the Council of Governors'. The Committee responsible for the remuneration of Executive Directors is described below.

The role of the Non-Executive Nominations and Remuneration Committee

The Non-Executive Nominations and Remuneration Committee ('the Committee') advises the Board on matters regarding the remuneration and terms of service for Executive Directors and senior managers. The Committee is established for the purpose of overseeing the recruitment and selection process for Executive Directors and Associate Directors i.e. senior managers, and the appointment of formal Board positions, for example the Senior Independent Director. The Committee's second purpose is to determine the remuneration and terms of service of Executive Directors and Associate Directors.

The term 'senior managers' covers our employees in senior positions, who have authority and responsibility for directing and controlling major organisational activities. These employees influence the decisions of the entire organisation, meaning that the definition covers the Chief Executive and Board-level directors.

The advice offered covers all aspects of salary, including performance-related pay and bonuses, as applicable, pensions, provision of cars, insurance, and other benefits. Advice on arrangements for termination of contracts and other general contractual terms also falls within the remit of the Committee. Specifically, the Committee is charged with:

- advising on appropriate contracts of employment, including remuneration, for senior managers
- monitoring and evaluating the performance of individual senior managers
- making recommendations regarding the award of performance-related pay, based on both the organisation's performance and the performance of individuals
- advising on the proper calculation of any termination payments.

The Committee is empowered to obtain independent advice as it considers necessary. At all times, it must have regard to our performance and national arrangements for pay and terms of service for senior managers.

The Committee meets several times a year, to enable it to make its recommendations to the Board. It formally reports to the Board, explaining its recommendations and the basis for the decisions it makes.

The Committee's membership did not change during the year remained the Chairman, Vice-Chair, Senior Independent Director and the Chair of the People Committee. The Chief Executive and other senior managers should not be present when the Committee meets to discuss their individual remuneration and terms of service but may attend by invitation from the Committee to discuss other staff's terms. Accordingly, the Chief Executive and the Chief People Officer attend the Committee when required. The Trust Secretary attends the Committee in an advisory capacity.

Chairman and Non-Executive Director remuneration

The Chairman's and Non-Executive Director's remuneration is overseen by the Governors' Nominations and Remuneration Committee ('Committee') as outlined in the Accountability Report 'Committees of the Council of Governors' section. The

Committee makes recommendations to the Council of Governors on the Non-Executive Directors and Chairman's remuneration levels, albeit from 2019/20 the Committee has reflected in its deliberations, the new remuneration framework issued by NHSEI in November 2019. The Chairman and Non-Executive Directors receive spot level remuneration but can claim reasonable expenses, for example travel expenses, as per other employees.

A review of remuneration levels applicable to Non-Executive Directors and the Chairman was undertaken during the year. The Committee was cognisant of the new remuneration framework and took the decision to maintain current levels of remuneration. Some Non-Executive Directors receive an additional one-off responsibility allowance based on Board positions held. No uplift in responsibility allowances was made during 2021/22.

The remuneration package for the Chairman and other Non-Executive Directors is made up of:

Item	Rationale
Remuneration*	£51,000 per annum for the Non-Executive Chairman - three days per week
Remuneration	£13,500 per annum for all other Non-Executive Directors - three days per month
Remuneration	Additional responsibility allowance of £3,000 for the Chair of the Audit Committee
Remuneration	Additional responsibility allowance of £1,500 given to the Senior Independent Director (SID*)
Remuneration	Additional responsibility allowance of £1,000 given to the Vice Chair
Expenses	Chairman and Non-Executive Director mileage rates are aligned with latest guidance: 56p per mile for the first 3,500 miles reducing to 20p per mile thereafter. All other expenses remain in line with organisational policy.

Policy on payment for loss of office for senior managers

Senior managers are employed on substantive contracts of employment and are employees of the organisation. Their contracts are open-ended employment contracts which can be terminated by either party by giving notice in accordance with their individual service contract.

Our normal disciplinary policy applies to senior managers, including the sanction of instant dismissal for gross misconduct. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

Governors' expenses

Governors may be reimbursed for legitimate expenses, incurred during their official duties, as governors of the Torbay and South Devon NHS Foundation Trust.

During the financial year, there were no claims for reimbursement of governors' expenses as most governor events and activities were held virtually. During the financial year, a Governor was paid expenses to reimburse costs incurred while attending meetings of the Foundation Trust and at external training and development events.

	31 March 2021	31 March 2022
Number of Governors in office	26	26
Number of Governors receiving expenses	3	1
Total expenses paid to Governors	£59.36	£18.00

Fair pay multiple (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in Torbay and South Devon NHS Foundation Trust in the financial year 2021/22 was £210,000 - £212,500 (2020/21, £210,000 - £215,000). This was 6.8 times (2020/21, 7.1) the median remuneration of the workforce, which was £31,534 (2020/21, £29,657).

The decrease in ratio from 7.1 to 6.8 in 2021/22, is due to a combination of factors namely, a change in highest paid director and slight salary increase in comparison to the previous highest paid director in 2020/21, by 0.68% and the increases in mid-point salary of 6.33% and in lowest Agenda for Change (AfC) band of 3.0%.

The highest paid director in 2021/22 was Mr I Currie, previously this was Dr R G Dyer in 2020/21. In 2021/22, 3 (2020/21, 4) employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £18,546 to £262,188 (2020/21, £18,005 - £348,082).

Total remuneration includes salary and non-consolidated performance-related pay. It does not include benefits-in-kind, severance payments, employer pension contributions and cash equivalent transfer value of pensions.

The median calculation is based on the full-time equivalent staff of the Foundation Trust at the reporting period end date on an annualised basis.

Fair pay multiple (audited information) – 25th and 75th Percentile

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021/22 was £210,000 - £215,000 (2020/21, £210,000 - £215,000). There has been no change. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not

include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £18,546 to £262,188.16 (2020/21, £18,005 to £348,082).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 15%.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

	2021-22			2020-21		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Salary component of pay	£21,777	£31,534	£39,042	Prior year comparatives not mandatory	£29,657	Prior year comparatives not mandatory
Total pay & benefits excluding pension	£21,777	£31,534	£39,042	Prior year comparatives not mandatory	£29,657	Prior year comparatives not mandatory
Total pay & benefits excluding pension: Pay ratio for highest paid director	9.8:1	6.7:1	5.4:1	Prior year comparatives not mandatory	7.2:1	Prior year comparatives not mandatory

Definition of 'senior managers'

The definition of 'senior managers' is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. This includes the Chief Executive, Chairman, Executive, Associate and Non-Executive Directors. This definition covers all those who hold or have held office as Chairman, Non-Executive Director, Executive Director, or Associate Director of the organisation during the reporting year. It is irrelevant that:

- an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment)
- an individual's title as director included a prefix such as 'interim, acting, temporary or alternate'
- an individual was engaged via a corporate body, such as an agency, and payments were made to that corporate body rather than to the individual directly.

Liz Davenport, Chief Executive
21 June 2022

Part IV – Staff Report

Analysis of staff costs (audited information)

The Foundation Trust is required to provide an analysis of staff costs, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other staff'.

	2021-22			2020-21		
	Total	**Permanently Employed**	**Other**	**Total**	**Permanently Employed**	**Other**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Salaries and wages	232,433	231,436	997	220,906	220,651	255
Social security costs	21,588	21,588	-	19.946	19,946	-
Apprenticeship levy	1,125	1,125	-	1,047	1,047	-
Employer's contributions to NHS pensions	27,827	27,827	-	26,260	26,260	-
Pension cost – Employer contributions paid by NHSE/ NHSI on Trust's behalf (6.3%)	12,199	12,199	-	11,522	11,522	-
Pension cost - other	50	50	-	58	58	-
Temporary staff	13,247	-	13,247	7,630	-	7,630
Total staff costs	**308,469**	**294,225**	**14.244**	**287,369**	**279,484**	**7,885**
Of which: Costs capitalised as part of assets	2,608	2,608	-	1,626	1,626	-

The Foundation Trust incurred £85,000 (2020/21 £182,000) in respect of other post-employment benefits, other employment benefits, or termination benefits. The Foundation Trust did not second any staff in either year to other organisations, instead where staff were supplied to other organisations the Trust generated an income from this service.

Analysis of worked full time equivalents (FTEs) (audited information)

We are required to provide an analysis of average staff numbers, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other' staff.

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The 'contracted hours' method of calculating whole time equivalent number is used, that is, dividing the contracted hours of each employee by the standard working hours. Staff on outward secondment are not included in the average number of employees.

During the year we continued to review the way in which we categorise staff numbers, in order to improve alignment with NHS Digital's guidance on the categorisation of staff using occupation codes.

	2021/22			2020/21
NHSI Staff Group	Total Number	Permanently Employed	Other Number	Total Number
Allied Health Professionals	523	508	15	485
Health Care Scientists	93	93		94
Medical and dental	574	271	302	531
NHS infrastructure support	1151	1094	57	1123
Other Scientific, therapeutic and technical staff	348	332	16	382
Registered ambulance service staff	10	10		11
Registered nursing, midwifery and health visiting staff	1292	1264	29	1242
Support to clinical staff	1897	1768	129	1906
Grand Total	5887	5339	548	5774

Analysis of sickness absence

We continue to focus on the overall health and wellbeing of our people while supportively managing sickness absence. Our sickness absence rate for 2021/22 compared to the previous four years is shown below. The last twelve months has seen a significant increase in sickness due to the impact of COVID-19 related absence.

Year	12 months sickness	FTE	FTE days available	FTE days lost to sickness absence	Average number of days sickness absence
2017/18	4.09%	5,163	1,884,585	77,054	9.2
2018/19	4.23%	5,177	1,889,505	89,859	9.5
2019/20	4.45%	5,410	1,974,776	87,942	10.0
2020/21	4.02%	5,667	2,068,557	83,152	9.0
2021/22	5.02%	5,806	2,119,241	106,286	11.3

Source: from the Electronic Staff Record (ESR)
*Period covered: April 2021 to March 2022
*Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year.
*The number of Full-Time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
*The number of FTE days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
*The average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

Analysis of staff turnover

Information showing our staff turnover data can be accessed via the following link to the NHS Digital website NHS workforce statistics - NHS Digital

Staff policies and actions applied during the year

We continue to be committed to providing an inclusive environment for our patients, staff, and visitors. We believe in providing equity in our services, in treating people fairly with respect and dignity and in valuing diversity both as a health and care services provider and as an employer.

Our diversity and inclusion policy set out the responsibilities of the organisation, our staff, and people who use our services. We actively promote a culture that values difference and recognises that people from different backgrounds and experiences bring valuable knowledge and insights to the workplace and enhances the way we work. We strive to be inclusive, to value, respect and embed diversity in all areas across the organisation. This will support us to recruit and retain a diverse workforce that reflects the communities we serve. Our diversity and inclusion policy afford equal protection to those who access our services, ensuring people are involved in their care and our workforce, ensuring our people have fair and equal opportunity.

We are committed to compliance with the Equality Act 2010, and as part of the subsequent Public Sector Equality Duty, we are dedicated to:

- eliminating discrimination
- promoting equality of opportunity
- fostering good relations.

All our policies continue to be subject to a rapid or full (E) quality impact assessment which aims to tackle discrimination or disadvantage at the outset.

A number of policies relating to equality, diversity and inclusion have been updated this year. To further promote inclusive practice our disciplinary policy has been re-written in alignment with a restorative just and learning approach and will be ratified in Spring 2022. The accessible information, patient transgender and staff trans, non-binary and intersex equality policies have all been updated to reflect latest guidance and local changes. Our agile working and home working policies are in place and have been updated.

Our employability policy supports those who may experience disadvantage to find sustainable employment through experience-based work placements. We support a range of people to develop their employability skills in a safe environment through our work experience programmes, traineeships if appropriate, apprenticeships and eventually through to securing employment.

We have also joined the disability confident initiative (this replaced the √√ (2 ticks) scheme) and we are a disability committed employer who aims to progress to level two disability confident status in 2022. One in three of our people are unpaid carers (source National Staff Survey 2021) and we have joined the employers for carers initiative and achieved level 2 status – accomplished in providing carer support.

We continue to be a ‘Mindful Employer’, supporting health and wellbeing at work and a key enabler to this is the ‘looking after our people’ pillar of our people plan and promise. The plan is reflective of the national priorities, integrated care system (ICS) and organisational priorities and a number of actions have been undertaken during year one of the people plan that support the health and wellbeing of our people. These include:

- the appointment of a ‘Wellbeing Guardian’ who champions staff wellbeing at Board level
- over 120 wellbeing buddies across the organisation have been trained to be the local first line of support and signposting to anyone who needs extra help in relation to their wellbeing
- our anti bullying network has been established and promoted
- to support and sign post our people to the wealth of wellbeing support available we have produced a ‘Wellbeing Wall’
- to support teams our wellbeing and organisational development team have been going to teams to provide a space for them to talk about what is going on for them

- our health and wellbeing pulse survey undertaken in January 2022 states that 53% of the respondents had the opportunity to discuss their wellbeing and 78% of these said that it had a positive outcome on their wellbeing.

A series of actions have been identified as part of our people plan for 2022, as part of a three-year strategy to make our organisation a great place to work.

We recognise that there may be times when our people experience episodes of poor wellbeing. For these members of staff we have policies in place to ensure they get the support and guidance and reasonable adjustments they need to assist them through this difficult time. Our occupational health service is focussed on the safety, health and wellbeing of our staff, patients and visitors. We have been through a formal tendering process to commission occupational health services for a further three years and Optima Health is our occupational health provider.

We offer a full range of occupational health services, which are available to all staff including the following:

- health promotion as well as health information and advice
- health surveillance for employees identified as ‘at risk
- workplace assessments
- immunisation programmes
- training and policy advice
- infection control including ‘needlestick hotline’
- baseline screening for new employees.

We have an Employee Assistance Programme (EAP) that staff can access themselves for a variety of issues they may be concerned with including musculoskeletal and mental health services. Our EAP has been particularly important during the COVID-19 pandemic and has been a valuable resource to employees during this period.

Our corporate health and safety team recently moved into our estates and facilities management directorate. In conjunction with our Health and Safety Committee and with other relevant stakeholders and teams, the corporate health and safety team are developing a cultural improvement plan for organisational safety which focusses on training, individual accountability and improved reporting of hazards.

We have recently appointed a corporate health and safety manager and we plan to further strengthen the team in 2022/23.

University Hospitals Plymouth NHS Foundation Trust continue to support the delivery of our fire management plan under the leadership of the Deputy Director of Environment. As part of a wider organisational re-design within the Estates and Facilities Management division, it is anticipated that a Fire Safety Advisor will be directly employed by the Trust in half two of the 22/23 financial year.

We manage health and safety through a series of steering groups and committees which are attended by clinical and non-clinical colleagues, as well as relevant

external consultants and regulators. These include the health and safety committee, the fire safety group, the asbestos safety group and the water safety group.

This year our speaking up vision was embedded into the development of our people plan in order to further increase awareness of the routes available to all staff about how they can feel safe and confident in speaking up. This is enabling an increasing number of people who are speaking up via the F2SU Guardians with concerns including patient safety, quality of care and cultures of bullying and harassment. Staff can also speak up to through their line management chain or contact the guardian generic email. There is dedication information and clear contact details on our staff intranet. Digital induction training and training delivered face to face and vis MS Teams has continued for specific groups of staff. We plan to further improve how staff can safely speak up through the introduction of an anonymous electronic platform in 2022/23.

We have continued to grow our coaching culture. Using the coaching principles in our interactions in groups and one-to-ones, has shown to enhance the skills of communication. Coaching is one of the most cost-effective development investments that any organisation can make in their staff. One-to-one coaching not only helps and supports individuals to enhance their own work practices, but more importantly their wellbeing. Coaching has been an invaluable element of the support services to help during the COVID-19 pandemic. Coaching continues to be available for all staff at all levels and focuses on how you want things to be, what you need to achieve and how you are going to get there.

The coaching collective is a group of staff with different backgrounds, experiences and roles, who have been trained in advanced coaching skills to be able to support staff. Feedback and evaluation of the service continues to prove positive, enabling some staff to remain at work and supporting others to come back to work more quickly than anticipated. Further work will be undertaken in 2022/23 to train and recruit more coaches from a more diverse background to strengthen our level of inclusivity.

This year we have offered a bespoke coaching skills training programme for our ethnic minority staff. We also undertook the training of additional mediators who support us to. resolve relationship difficulties between staff at an early stage, avoiding where possible a formal employee relations process and fostering alignment to our restorative just and learning approach.

Our Equality Business Forum (EBF) continues to provide the leadership for our employee network groups which include our disability network and our lesbian, gay, bisexual and transgender group (LGBTQ+). To further reflect the diversity and needs of our workforce we now have the an under 30s network, a menopause group, and a mental health group. Our BAME engagement group has significantly grown and now has more than 60 members. In addition, we have active representatives on the Devon-wide BAME network.

The introduction of inclusivity representatives on some interview panels has been led by representatives of these groups ensuring recruitment processes are inclusive and

appointing a diverse future workforce. Our EBF continue to be key advisors and influencers to significant key organisational strategies that include our building a brighter future programme and our workforce digital literacy: preparing our staff for a digital future.

Our people plan reflects the progress we need to make to improve the experience of **all** staff in our organisation with a particular focus on belonging. All our EBF networks have been engaged in the production of our people plan to support creating the right conditions for everyone's voice to be heard and bringing to life a truly diverse workforce that is reflective of people in our local population.

Through the belonging pillar of our people plan, we have undertaken significant engagement with under-represented groups of staff in order to better understand what is needed to ensure a culture of inclusion and belonging. The themes identified from this work together with the results of the staff survey are informing the work for 2022/23. These include:

- promotion and raising awareness of Ramadan, Diwali and Chinese New Year through articles, videos and offering diverse foods in our staff canteen
- celebrating Black History Month with a webinar of eminent key note speakers, poetry events and videos.

2021 National NHS Staff Survey

Staff experience and engagement

Our strategy fully recognises the importance of staff experience and engagement as a core enabler to delivering our purpose – to support the people of Torbay and South Devon to live well. Research has shown a clear relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally.

We have a range of well-established forums for staff to share their views and to engage with us including:

- Trust Talk – monthly briefing session for all staff from the Executive Team which is livestreamed, with opportunities for question and answers;
- 'Just Ask!' noticeboard for staff to ask questions or raise issues with the Executive Team;
- Staff Surveys including the national annual staff survey and quarterly people pulse;
- Bespoke forums including the mental health forum and menopause group;
- Freedom to Speak Up Guardian and champion network;
- Equality business forum and staff network groups;
- Joint consultations/negotiations with the Trade Unions;
- Wellbeing buddies and anti-bullying advisor networks;
- Staff Governors.

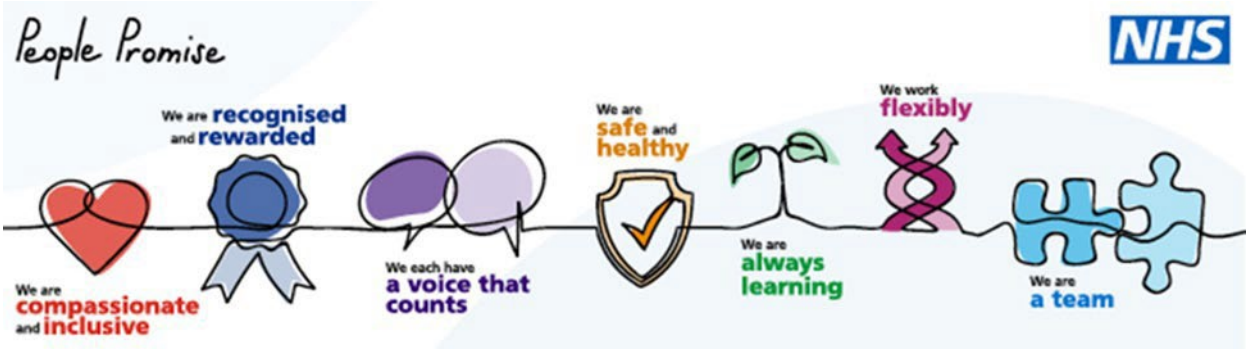
NHS staff survey

The past 12 months has continued to challenge each and every one of our teams as we have continued to respond to the pandemic, at the same time as planning for the recovery of our services and building a brighter future. The annual staff survey provides a helpful insight into how the pandemic has affected the experience of our people at work.

The 2021/22 NHS Staff Survey underwent important changes since the 2020/21 iteration. This involved extending the inclusion criteria as well as making some changes to the content of the questionnaire. Among these improvements, and perhaps the most significant, has been the realignment of the survey questions to the seven People Promise elements, where previously these were aligned to themes. The People Promise is based upon what our NHS people have said matters most to them and would make the greatest difference in improving their experience in the workplace. The people promise was published as part of the People Plan in 2020/21 to support the delivery of the NHS Long term plan. Aligning the survey allows us for the first time to measure, consistently and robustly, the working experience of our people across the NHS in England. Alongside the seven Promise elements we have retained the two themes of Engagement and Morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Despite the significant pressures on our teams, we saw an increase in the overall response rate from 42% in 2020 to 46% in 2021. This is equivalent to the response rate of our benchmarking group - Acute and Acute & Community Trusts

The feedback is presented below, together with the two previous reporting periods;



2021/22

Elements	Foundation Trust 2021	Benchmarking Group	Foundation Trust 2020
We are compassionate and Inclusive	7.2	7.2	Not available as year 1 of new reporting categories
We are recognised and rewarded	5.9	5.8	
We each have a voice that counts	6.7	6.7	
We are safe and healthy	5.9	5.9	
We are always learning	5.1	5.2	
We work flexibly	6.1	5.9	
We are a team	6.7	6.6	
Staff engagement	6.8	6.8	7.0
Morale	5.8	5.7	6.1

2020/21 and 2019/2020

	Foundation Trust 2020/21	Benchmarking group	Foundation Trust 2019/20	Benchmarking group
Equality, diversity and inclusion	9.2	9.1	9.2	9.2
Health and wellbeing	6.1	6.1	6.1	6.0
Immediate managers	6.9	6.8	6.9	6.9
Morale	6.4	6.2	6.3	6.2
Quality of appraisals	*Theme removed from reporting*		5.1	5.5
Quality of care	7.3	7.5	7.3	7.5
Safe environment – bullying and harassment	8.1	8.1	8.2	8.2
Safe environment – violence	9.5	9.5	9.5	9.5
Safety culture	6.6	6.8	6.6	6.8
Staff engagement	7.0	7.0	7.0	7.1
Team working	6.5	6.5	6.6	6.7

Our feedback this year, as in previous years, indicates that we perform above or in line with our benchmarking group in all but one of the nine elements. We perform particularly favourably in regards to working flexibly – which is key not only to retention but to attracting talent. We also perform well in regards to being recognised and rewarded and we are a team – which we know has been the most important and utilised source of support during the pandemic. The area for development is around our appraisal process for which work has already commenced. Regrettably, but perhaps unsurprisingly we have seen a decline in both staff engagement and staff morale. Work pressure is the largest contributor to the decline in morale, and a reduction in advocacy for the decline in staff engagement. Whilst, the overview is not comparable, many of the questions that make up the elements and sub elements remain unchanged. This enables us to continue to identify and celebrate our strengths, including diversity and equality and identify areas for improvement which include burnout and our health and safety climate.

Future priorities

Our People Promise describes how Torbay and South Devon Foundation Trust will feel as a great place to work. Our People Plan describes how we will create the conditions for people to thrive, and deliver exceptional integrated health and care, whatever essential role we play.

Having approached the end of year one of our People Promise and Plan we have celebrated key achievements in the following areas;

- Looking after our people
- Belonging in the NHS
- New ways of working
- Growing for the future
- Creating the conditions to enable transformation

Our year two priorities build upon the essential foundations of year one and continue to be informed by our staff experience feedback. The need for meaningful impact has led to our organisational design and development approach to ensure our processes and systems align with building capability and confidence, to ensure meaningful impact is achieved.

Performance against the People Plan will be monitored through the Trusts People and Education Governance Group and ultimately the People Committee as a sub-committee of the Board.

Relevant union officials

Number of employees who were relevant union officials during the relevant period	3
Full-time equivalent employee number	1.88

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1 – 50%	1
51% - 99%	1
100%	1

Percentage of pay bill spent on facility time

Total cost of facility time	£65,627.84
Total pay costs	£280,434,420.26
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time divided by total pay bill) x 100	0.023%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on trade union activities by relevant union officials during the relevant period + total paid facility time hours) x 100	100.00%

Consultancy costs

Expenditure on consultancy costs for 2021/22 was £362,000 compared with £29,000 for 2020/21.

Off-payroll report

PES (2018)13 requires the Foundation Trust to seek assurance from individuals working through off-payroll engagements, that all their tax obligations are being met. This is required for existing and new engagements that during the period between 1 April 2021 and 31 March 2022 cost more than £245 per day and were engaged for more than six months.

The Foundation Trust is required under the reporting requirements published by HM Treasury in relation to PES (2018)13, to report if it had any engagements which met the disclosure requirements. The Foundation Trust can confirm that it had no engagements requiring disclosure.

Off-payroll worker engagements as at 31 March 2022

Number of existing engagements as of 31 March 2022	3
Of which…….	
Number that have existed for less than one year at time of reporting	1
Number that have existed for between one and two years at time of reporting	2
Number that have existed for between two years and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All off-payroll workers engaged at any point during the year ended 31 March 2022

Number of off-payroll workers engaged during the year ended 31 March 2022	8
Of which…….	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	8
Number of engagements reassessed for consistency/assurance purposes during the year	4
Of which: Number of engagements that saw a change to IR35 status following review	0
Number of engagement where the status was disputed under provisions in the off-payroll legislation	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2022

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	20

Note: The Foundation Trust has a number of doctors who meet the financial criteria but have no significant financial responsibility and therefore fall outside of the scope of the reporting requirement.

Staff exit packages paid in year (audited information)

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

Exit package cost band (including any special payment element)	Compulsory redundancies		Other departures agreed		Total of exit packages		Departures where special payments have been made	Special payment element included in exit packages
	Number	Cost £'000	Number	Cost £'000	Number	Cost £'000	Number	Cost £s
Less than £10,000	-	-	19	91	**19**	**91**	-	-
£10,001 - £25,000	-	-	3	57	**3**	**57**	-	-
£25,001 - 50,000	-	-	11	437	**11**	**437**	-	-
£50,001 - £100,000	-	-	4	242	**4**	**242**	-	-
£100,001 - £150,000	-	-	-	-	**-**	**-**	-	-
£150,001 - £200,000	-	-	-	-	**-**	**-**	-	-
Greater than £200,000	-	-	-	-	**-**	**-**	-	-
Total number of exit packages by type	**-**	**-**	**37**	**827**	**37**	**827**	**-**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of the national Agenda for Change scheme where payment has been made in lieu of notice, or the locally agreed MARS scheme which is based on national guidance. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages: other (non-compulsory) departure payments (audited information)

	2021/22		2020/21	
	Agreements Number	**Total Value of Agreements £000**	**Payments agreed Number**	**Total value of agreements £000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	18	719	1	80
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice *	19	108	25	112
Exit payments following Employment Tribunals or court orders	-	-		-
Non-contractual payments requiring HMT approval **	-	-	-	-
Total	37	827	26	192

* any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice.

Diversity and inclusion

Diversity and Inclusion is at the forefront of everything we do within the NHS. We are committed to building an organisation that puts patients’ and service users wishes at the centre and removing the barriers that hinder staff and prevent them working to their full potential. All staff are kept informed and are aware of the NHS Constitution and our organisational values. Our staff can be assured that they will continue to be supported and valued to carry out their duties effectively, ensuring that everyone counts.

Our equality, diversity and inclusion programme is integral to the delivery of our people plan and is key to improving the experience of our people who are part of under-represented groups.

Our focus for 2022/23 will be on building from the themes identified through in-depth engagement with our people. These themes include raising cultural awareness,

developing career pathways, supporting career progression, strengthening our staff networks and addressing bullying and harassment.

Workforce Disability Equality Standards (WDES)

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and requires the Trust to annually self-assess against 13 indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement.

Nine of the 13 WDES indicators are taken from the National Staff Survey. The table below shows the Trusts performance against the WDES standard for the last two years and in comparison, to the national average. The broad headlines are:

- With the exception of equal opportunities for career progression, the experience of our people with long term conditions is in line or better than the national average.

- The areas that have seen the biggest improvements in comparison to 2020 are; the percentage of staff with LTC feeling pressure to come to work despite feeling unwell which has improved by over 6%. Followed by experience of BHA by managers which has improved by over 3% and the percentage of staff with LTC reporting experience of BHA which has improved by 2.6%.

- Conversely the areas that have seen the biggest decline in comparison to 2020 are; the percentage of staff with LTC feeling there are equal opportunities for career progression which has reduced by over 5%. This is followed by the percentage of staff with LTC experiencing BHA by patients which has increased by 4%. The percentage of staff with LTC stating that there have been adequate adjustments for them to carry out work has reduced by nearly 4%.

- The areas in which we see the greatest disparity in experience between staff with and without a LTC are; equal opportunities for career progression which is 9.3% lower for staff with LTC and experience of BHA from staff which is 8.6% higher.

	LTC or illness 2020	Without LTC 2020	LTC or illness 2021	Without LTC 2021	LTC or illness average 2020
% staff experiencing BHA from patients, relatives or public	27.9%	22.9%	32.1%	25.4%	32.4%
% staff experiencing BHA from manager	19.4%	9.5%	16.3%	8.7%	18%
% staff experiencing BHA from colleagues	26.8%	16.9%	24.5%	15.9%	26.6%
% of staff that reported experience of BHA	45.4%	44.6%	48%	48.6%	47%
% staff believing equal opportunities for career progression	55.4%	57.3%	49.7%	59%	51.4%
% staff feeling pressure from manager to come to work despite feeling unwell	31.5%	22.3%	25.1%	19.8%	32.2%
% staff satisfied with the extend Trust values their work	35.5%	47.5%	34%	40.8%	32.6%
% staff saying the Trust has made adequate adjustments for them to carry out work	80.2%		76.3%		70.9%
Staff engagement score (0-10)	6.7	7.1	6.4	6.9	6.4

*National average

[Note: BHA means bullying and harassment]

Actions undertaken

- Anti-bullying advisors providing a safe space and support for staff
- Reasonable adjustment information refreshed and available on the EDI web pages.
- 8 new mediators recruited and trained to proactively address bullying and harassment in the workplace
- Campaign launched to encourage staff to disclose and update their protected characteristics
- A task and finish group has recently been established to understand and address the issues relating to reasonable adjustments being made.

What Next

- Review Anti-bullying Network concept and approach ensuring a diverse membership
- Proactive focus on bullying and harassment to include raising awareness of incivility, personal attitude and behaviour impact on others
- Raise awareness of mediation network to provide proactive support and early intervention
- Understand barriers to career progression for people through Disability Network and staff workshops
- Renewed focus on Disability Network to increase membership and diversity of LTC
- Recruit disability inclusivity representatives to be part in interview panels ensuring inclusive recruitment practices
- Raise awareness of reasonable adjustment options and embed practice through task and finish group
- Modernise the EDI mandatory training for all staff raising awareness and educating everyone on EDI matters and personal impact on others

Workforce Race Equality System

The Workforce Race Equality Standard (WRES) was introduced in 2015 to hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between our black and minority ethnic (BME) and white staff.

The WRES 2016-21 report recently received from NHSI/E features a summary of workforce race equality standard (WRES) metrics for our Trust. This is the first time such a report has been generated on a Trust by Trust basis throughout the country. The intention is to provide detailed information for each Trust enabling us to identify where progress has been made, but importantly to also identify where there is a required focus of attention for future action, to improve this critical aspect of our workforce agenda. This in turn will support the refinement of our WRES action plan and annual report, required under the NHS standard contract.

The current reporting year for the purposes of this report is 2021. Data for indicators 1 to 4 are taken from Strategic Data Collection Service WRES form submissions relating to the workforce as at the end of March 2021. Data for indicators 5 to 8 come from the NHS Staff Survey run in November and December 2020. Whilst technically not part of the NHSI/E report, we have also referred to our 2021 NHS Staff Survey to indicate whether there is an improving or deteriorating trajectory. The broad headlines are:

- Percentage of staff experiencing harassment, bullying or abuse (HBA) from patients, relatives or the public**.** The report rates the percentage of staff experiencing HBA from patients as similar for white staff, 23.7% and for BME staff 31%, However, we know from the 2021 national staff survey that these figures have increased for white staff 26.5% and BME staff, 33%. Whilst the disparity has not changed, the increasing prevalence is of concern.

- Percentage of staff experiencing harassment, bullying or abuse (HBA) from staff**.** The report rates the percentage of staff experiencing from other staff as similar for white staff, 24.1% and for BME staff 25.2%. We know from the 2021 national staff survey that these figures have continued to improve for both white staff 22.3% and BME staff, 24.6% and remains below the national average.

- Percentage of staff who believed the Trust provided equal opportunities for career progression or promotion. The report rates the percentage of staff who believe that the trust provided equal opportunities for career progression as similar for BME staff, 75.7% and for white staff 85.7%. Whilst 6% lower than our percentage in 2019, and whilst not directly comparable due to a slight change in wording, we do know that there has been an improvement in the 2021 national staff survey feedback.

- Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleagues. The percentage of staff experiencing discrimination at work from other staff in the last 12 months was significantly higher for BME staff, 15.1% than for white staff, 5.8%. it is 5% higher than in 2019 Better than the reported national average figure 2020 of 16.8%. However, not only the disparity but the prevalence is increasing. We know from the 2021 national staff survey that this picture continues to deteriorate with 17.3% of our BME staff reporting experience of discrimination as opposed to 6.3% of white staff. The increasing prevalence is of concern and work must continue to better understand and improve the experience of our BME colleagues.

In summary, the Trust findings compare favourably to the national average in two of the four questions. However, in comparison to the Trusts performance in 2019, the findings suggest a deteriorating experience for our BME staff and potentially a widening disparity of experience in comparison to white colleagues. The staff survey results for 2021 and the detailed WRES report for the organisation would indicate an

improving trajectory for Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff and indicator 7. Percentage of staff who believed the trust provided equal opportunities for career progression or promotion as an area of strength.

	BME 2020 Staff Survey	White 2020 Staff Survey	BME 2021 Staff Survey	White 2021 Staff Survey	BME Average 2021 Staff Survey	White Average 2021 Staff Survey
% staff experiencing BHA from patients, relatives or public	31%	23.7%	33.0%	26.5%	28.8%	26.5%
% staff experiencing BHA from staff	25.2%	24.1%	24.6%	22.3%	28.5%	23.6%
% staff believing equal opportunities for career progression	75.7%	85.7%	51.0%	57.3%	44.6%	58.6%
% staff experiencing discrimination at work from manager or colleagues	15.1%	5.8%	17.3%	6.3%	17.3%	6.7%

Note: BHA refers to bullying and harassment

*National average

Actions undertaken

- A BME network in the Trust has been set up as well as a new Devon Wide BME Network chaired by the Foundation Trusts BME Equality, Diversity and Inclusion Lead.
- A number of issues have been promoted and awareness raised relating to risk assessments, the impact of COVID on our overseas staff with families abroad, Black Lives Matter, Ramadan and India's COVID crisis.
- Our BME staff have been supported to send out key messages within the organisation.

- Vlogs were delivered by the Chief Executive at the beginning, during and end of Ramadan.
- The BME EDI Lead is a Vaccine Ambassador and was interviewed by a local TV broadcaster to encourage the uptake of the vaccine.
- The Trust has worked alongside our International nurse's team, to improve the experience of our BME nurses and to monitor their journey within the organisation.
- A bullying and harassment project has been advertised and the training of advisors has taken place.
- The Foundation Trust Board of Directors participated in a facilitated development session discussing equality, diversity and inclusion and what this means strategically and their leadership role for the organisation.

Next steps

- Continue to grow our BME network that provide a safe space for their voices to be heard, to share experiences, offer peer support and have a sense of belonging.
- Ensure we have a rolling programme of events and spaces to increase confidence and trust of our staff. Encourage our BME staff to lead and take part in celebrating Diversity and Inclusion across the organisation.
- Implement listening events to hear the first-hand the experiences of our staff. Workshops are underway to gain insight and better understand barriers to career progression. Encourage members to share their stories safely.
- Continue working with the community and the 'hard to reach' groups.
- Launch the Managers Essential Training Programme to raise awareness of bullying and harassment experiences, unconscious bias and the need for managers to be culturally competent and compassionate leadership training for managers to help support themselves and staff.
- Progress work to create an inclusive culture throughout the organisation through promoting self-awareness and ensuring recruitment processes are diverse and inclusive.
- Review our recruitment processes to support the recruitment of an inclusive and diverse workforce.
- Develop a range of resources for leaders and staff to engage in meaningful conversations around race and inequality.
- Address the lack of BME staff in Band 8A and above posts. Introduce Inclusivity reps on interview panels. Explore bespoke recruitment agencies and target recruitment and retention.
- Recruit members of BME staff to the Anti-Bullying Network. Campaign to encourage BME staff to join with support of the BME Network chair and the executives.
- Embark on a Reciprocal Mentoring Programme with an emphasis on race
- Promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, identifying any specific gaps requiring some targeted or bespoke programmes.
- Bespoke coaching programme for BME staff already underway as part of development offer.

- Modernise the EDI mandatory training for all staff raising awareness and educating everyone on EDI matters and personal impact on others

Gender pay differential

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The data in this report is based on a snapshot taken on 31 March 2021.

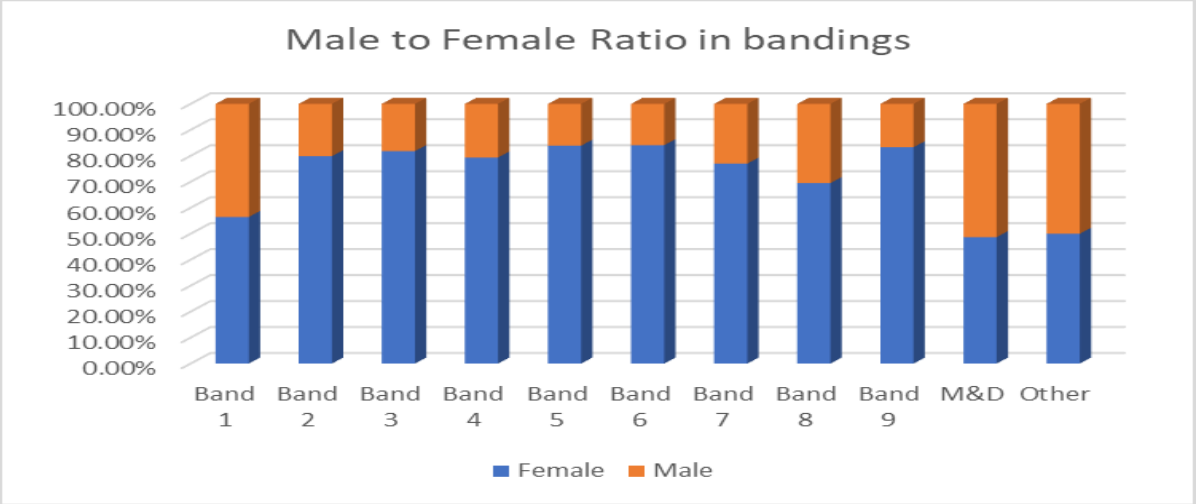
An analysis of our workforce as at 31 March 2021, split by directors, other senior managers and employees, is shown below:

	Male %	Male headcount	Female %	Female headcount
Executive Directors	50%	4	50%	4
Other senior managers	41.46%	34	58.54%	48
Employees	22%	1491	78%	5,252

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap analysis below shows the difference in the average pay between all men and women in a workforce. Generally, the average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. While a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower.

The current gender split within the overall workforce is 78% female and 22% male. The breakdown of proportion of females and males in each banding is as follows:



Average Gender Pay Gap

a) Average gender pay gap as mean average (all applicable staff)

	Male	Female	% difference
Mean hourly rate 2018	£18.76	£14.85	20.84%
Mean hourly rate 2019	£18.89	£15.22	19.44%
Mean hourly rate 2020	£19.51	£15.72	19.41%
Mean hourly rate 2021	£19.58	£16.07	17.89%

b) Average gender pay gap as median average (all applicable staff)

	Male	Female	% difference
Median hourly rate 2018	£14.16	£13.10	7.49%
Median hourly rate 2019	£14.21	£13.29	6.49%
Median hourly rate 2020	£14.73	£13.83	6.09%
Median hourly rate 2021	£14.58	£14.02	3.83%

Summary of results average gender pay gap

The overall percentage variance for the average hourly rate of pay as a mean average is low at 17.89% and this is further reduction from last year which was 19.41%. This calculation is based on the average hourly rate of 5,252 female staff compared to 1,491 male staff. Because the average is calculated over different numbers of staff (there are almost four times more female staff), some variance is to be expected.

The percentage variance for the median hourly rate of pay is 3.83%. This calculation is based on the average hourly rate at the mid-point for each gender group. This can be more indicative than the average hourly rate of pay as it is not impacted much by the female to male ratio.

However further investigation has shown that when medical and dental staff are removed from the calculations then the gender pay gap is in favour of female staff. It is the inclusion of our consultant body which shows to have a significant impact on the figures, as the majority of our senior consultants are predominantly male (145 male to 96 female consultants) and have a significant number of years seniority.

This impact can be seen on the mean hourly rate supporting the theory that medical and dental staff do influence the hourly rate which has risen to 12.57% after a three-year reduction trend. Male medical and dental staff have seen a 3.1% rise in their mean hourly rate in comparison to females who have seen a 2.3% average rise. On whole the Agenda for Change staff increase is less than 0.1% and insignificant against the whole figure. This can be related to the 60/40 split in male to female ratio for consultants.

Having reviewed the data there are two themes which stand out:

- when looking at the total workforce, male staff are disproportionately represented in the lowest and highest pay quartiles

- the most obvious imbalance of pay is amongst the medical and dental staff namely with regards to the historic clinical excellence awards (CEA) bonus pay.

It is the inclusion of our consultant body which shows a significant impact on the figures, reversing the female positive gender pay gap across the remainder of our workforce.

Analysis of our medical workforce continues to reveal its own complexities. The junior doctors show a pay gap in favour of female staff, but at more senior level then this is in favour of male employees, with a higher number of male consultants employed compared to female. The legacy of a predominantly male consultant body is slowly changing, as demonstrated by the current junior doctor workforce, which shows a higher number of female employees compared to male.

Additional information on our latest published Gender Pay Gap Report can be found on our website at Equality and Diversity - Torbay and South Devon NHS Foundation Trust and at the Cabinet Office website at Torbay And Southern Devon Health And Care Nhs Trust gender pay gap data for 2020-21 reporting year - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)

Apprenticeships

An apprenticeship is an ideal way for anyone to earn a wage while gaining a recognised qualification, developing professional skills and starting a valuable career.

We know that hiring apprentices helps all businesses and organisations to support and develop their local community – this is particularly important for us both in terms of offering opportunities to local people and ensuring that we have a motivated, skilled and qualified workforce.

We currently employ over 250 apprentices in a wide range of clinical and non-clinical roles. 200 of the apprentices are almost through into successful working roles, some of whom are now fully qualified clinical practitioners.

All our apprenticeships, including our degree level apprenticeships are fully funded and enable those who may not be in a position to take on a student loan to achieve their career aspirations.

As the largest employer in Torbay and South Devon we have a responsibility to use the resources available to us for the benefit of the whole community, and ensure that nobody is excluded, discriminated against, or left behind.

We will continue to support as many people as possible into our organisation, and the wider NHS, through apprenticeships.

Part V – Governance statements

Statement of compliance with the NHS Foundation Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, originally issued in 2012.

NHS Foundation Trusts are required to provide a specific set of disclosures in the annual report to meet the requirements of the Code of Governance.

Information relating to governance systems and processes is detailed in the Annual Report, and in particular the Annual Governance Statement. Details of the Constitution of the Board are given in the Accountability Report.

Mandatory disclosures

Relating to	***Code provision***	***Summary of requirement***	***Location in Annual Report***
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should also include this schedule of matters or a summary statement of how the board of directors operate, including a summary of the types of decisions to be taken by the board and council which are delegated to the executive management of the board of directors.	Accountability Report Pages 35-36 Governance Statements – Page 101
Board, Audit Committee, Nominations and Remuneration Committee(s)	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those	Accountability Report Pages 37 and 45

		committees and individual attendance by directors.	
Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including the description of the constituency or organisation they represent whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the lead governor.	Accountability Report Pages 48 - 50
Council of Governors	FT ARM*	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Accountability Report Page 48-49
Board	B.1.1	The board of directors should identify in the annual report each of the non-executive director it considers to be independent, with reasons where necessary.	Accountability Report Page 38
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Foundation Trust.	Accountability Report Page 46 and Appendix A - Pages 126 - 135
Board	FT ARM*	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	Remuneration Report Pages 67-68
Nomination and Remuneration Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability Report Page 38
Nomination and Remuneration Committee(s)	FT ARM*	The disclosure in the annual report on the work of the nomination committee(s) should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Not applicable
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before	No other significant

		appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	commitments to report
Council of Governors	B.5.6	Governors should canvass opinion of the Foundation Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report Pages 51-53
Council of Governors	FT ARM*	If during the financial year, the governors have exercised their power under paragraph 10C of Schedule 7 of the NHS Act 2006, to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties, then information on this must be included in the annual report.	Not applicable
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability report Page 46
Board	B.6.2	Where there has been an external evaluation of the board and/or governance of the Foundation Trust, the external facilitator should be identified in the annual report and statement made as to whether they have any other connection to the Foundation Trust.	Not applicable for the reporting period
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider	Accountability Report Page 54

		the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Annual Governance Statement page 121-123 Page 42
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Governance Statements Pages 107
Audit Committee/ control environment	C.2.2	A Foundation Trust should disclose in the annual report: (a)if it has an internal audit function, how the function is structured and what role it performs; or (b)if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability Report Pages 105
Audit Committee/ control environment	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, re-appointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations	Accountability Report Pages 39 and 40

		and compliance, and how those issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length or tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provided non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	
Board, Nomination and Remuneration Committee	D.1.3	Where an NHS Foundation Trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.	Appendix B Pages 137
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report Pages 52
Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS Foundation Trust's membership is and how the level and effectiveness of member engagement and report this in the annual report.	Accountability Report Page 51

Membership	FT ARM*	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Accountability Report Pages 52 and 53
Board/Council of Governors	FT ARM*	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust.	Accountability Report Pages 37 and 50

*FT ARM disclosures are required by the NHS Foundation Trust Annual Reporting Manual rather than the NHS Foundation Trust Code of Governance.

Comply or explain disclosures

NHS Foundation Trusts are required to provide a specific set of disclosures in relation to the provisions within Schedule A of the NHS Code of Governance. We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis and has complied with the Code during 2021/22, except for the following:

A.1.10	We do not have in place directors' and officers' liability insurance. Steps have been taken to ensure this is in place for the 2022/23 year.
B.1.2	The Board comprised an equal number of Non-Executive Directors (NEDs) and Executive Directors (EDs) for a part of the year. We appointed a NED with clinical background to the vacant post but the person left the Trust after only 2 months in post. A recruitment exercise is currently underway to fill one NED vacancy and another vacancy that is due to expire in December 2022.

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards. While doing this, the Board:

- meets formally at least bi-monthly in order to discharge its duties effectively. Systems and processes are maintained to measure and monitor the organisation's effectiveness, efficiency and economy as well as the quality, of its healthcare delivery
- reviews our performance against regulatory and contractual obligations and approved plans and objectives. Metrics, measures and accountabilities have been developed to assess progress and delivery of performance
- all directors are responsible to constructively challenge the decisions of the Board. Non-Executive Directors scrutinise the performance of the Executive Directors in meeting agreed goals and objectives and monitor the reporting of performance. If a Board member disagrees with a course of action it is minuted accordingly. The Chairman would then hold a meeting with the Non-Executive Directors. If the concerns cannot be resolved this should be noted in the Board minutes
- Non-Executive Directors are appointed for a term of three years by the Council of Governors. The Council of Governors has the authority to appoint or remove the Chairman or the Non-Executive Directors at a general meeting. Removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors
- Non-Executive Directors are determined by the Board to be independent
- no individual on the Board of Directors or Council of Governors holds positions at the same time of Director and Governor of any NHS Foundation Trust
- operates a code of conduct that builds on our organisational values to reflect high standards of probity and responsibility
- in discussion with the Council of Governors a Non-Executive Director covers the role of Senior Independent Director
- the Chairman ensures that the Board of Directors and the Council of Governors work together effectively and that directors and governors receive timely and clear information that is appropriate to carry out their duties
- the Chairman holds regular meetings with Non-Executive Directors without the Executive Directors present
- no independent external adviser has been a member of or had a vote on the Committees responsible for the appointments or remuneration of Executive or Non-Executive Directors
- the Committee responsible for setting levels of remuneration for Executive Directors has delegated authority from the Board to do so
- independent professional advice is accessible to the Non-Executive Directors and the Trust Secretary via the appointed independent external auditors and/or via external legal firms
- there is no full-time Executive Director that takes on more than one Non-executive Director role of another NHS Foundation Trust or another organisation of comparable size and complexity
- all Board meetings and Board Committee meetings receive sufficient resources and support to undertake their duties
- a going concern report is undertaken annually
- effective mechanisms are in place to ensure co-operation with relevant third-party bodies

- in accordance with the Code, our organisation is led by the Board of Directors who have joint and several responsibilities for the exercise of the powers of the Foundation Trust. Appointments to the Board both of Executive and Non-Executive Directors in the reporting period meant that the Board was fully constituted. The Board does not consider that its performance or balance was significantly impacted during any period of interim arrangements.

The Council of Governors:

- represents the interests of the organisation's members and partner organisations in the local health economy.
- has a code of conduct in place to ensure Governors adhere to the our best interests and values
- holds the Board of Directors to account for our performance and receives appropriate information on a regular basis
- governors are consulted on the development of our forward plans and arrangements are in place for them to be consulted on any significant changes to the delivery of our business plan if so required
- the Council of Governors meet on a regular basis in order for them to discharge their duties
- the governors elect a lead governor. As lead governor, the main function is to act as a point of contact with NHSEI, the Trust's independent regulator
- the directors and governors continually update their skills, knowledge and familiarity with our organisation and our obligations, to fulfil their role on various Boards and Committees
- our constitution is available on the website and outlines the clear policy and fair process for the removal from the Council of Governors of any governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties
- the performance review process of the Chairman and Non-Executive Directors involves the governors, is conducted by the Senior Independent Director and in accordance with NHSEI guidance. Each Executive Director's performance is reviewed by the Chief Executive. The Chairman reviews the performance of the Chief Executive
- the Committee responsible for setting remuneration of Non-Executive Directors and the Chairman adhere to the NHSEI guidance when reviewing levels of remuneration
- the Committee responsible for the appointment of Non-Executive Directors comprises a majority of governors
- the Chief Executive ensures that the Board of Directors and the Council of Governors act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman contemplates a course of action involving a transaction which the Chief Executive considers infringes these requirements, the procedures set by NHSEI for advising the Board and Council for recording and submitting objections to decisions will be followed. During 2021/22 there have been no occasions on which it has been necessary to apply the NHSI procedure
- our staff are required to act in accordance with NHS standards and accepted standards of behaviour in public life. We ensure compliance with the Fit and

Proper Person (FPP) requirement for the Board of Directors. All existing Directors completed a self- declaration. All new appointments are also required to complete the self- declaration and the full requirements of the FPP test have been integrated into the pre-employment checking process.

NHS oversight framework

NHSEI's System Oversight Framework provides the framework for overseeing providers and systems and identifying potential support needs to help them improve. The framework looks at six themes:

- quality of care, access and outcomes
- finance and use of resources
- preventing ill-health and reducing inequalities
- people
- local strategic priorities
- leadership and capability.

Based on information from these themes, providers and systems are segmented from 1 to 4, where '4' reflects those receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

On 15 October 2021, it was confirmed that we have been placed into SOF segment 3 and would therefore receive bespoke mandated support. The reason for the segment 3 rating was our underlying financial deficit.

In response to our segment three rating, we developed a series of timebound and measurable exit criteria. These have been agreed with ICS Devon and NHSE/I south west regional team. Progress against the exit criteria is regularly scrutinised through our governance processes, and reported monthly to the system improvement and assurance group.

Statement of the Chief Executive's responsibilities as the Accounting Officer of Torbay and South Devon NHS Foundation Trust:

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum i*ssued by NHS Improvement.

NHSEI in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Torbay and South Devon NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Torbay and South Devon NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities, and guidance
- confirm that the annual report and accounts, taken as a whole, is fair balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Liz Davenport, Chief Executive
21 June 2022

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that our organisation is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of Torbay and South Devon NHS Foundation Trust
- evaluate the likelihood of those risks being realised and the impact should they be realised
- to manage them efficiently, effectively, and economically.

The system of internal control has been in place in Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the organisation and these meet all statutory requirements and adhere to guidance issued by NHS Improvement in respect of governance and risk management.

We have a risk management strategy, which is reviewed and endorsed by the Board of Directors. The strategy provides the framework for managing risks across the organisation which is consistent with best practice and Department of Health and Social Care guidance. The strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of sub-committees that scrutinise and review assurances on internal control. These include the Audit Committee, Quality Assurance Committee, People Committee and the Finance, Performance and Digital Committee. Underpinning these sub-committees are the Executive-led groups – including the quality improvement group, risk group and other

groups managing the operational delivery of information management and technology, estates and people.

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality Assurance Committee. The Board of Directors receives a report from the Chair of each of the Board sub-committees. The Board of Directors also receives the Board assurance framework and corporate risk register at each meeting.

The risk group oversees all risk management activities across the organisation to ensure that the correct strategy is adopted for managing risk, controls are present and effective, action plans are robust for these risks that are being actively managed and that high risks are scored appropriately. The risk group is chaired by the Chief Finance Officer. Membership comprises all Executive and Associate Directors; other standing attendees include the Director of Health Informatics, Director of Corporate Governance, Corporate Governance Manager and the Risk Officer. In addition, the Executive Directors have in place a process whereby all significant risks to the achievement of service delivery unit and directorate objectives, NHS Improvement governance and compliance requirements and Care Quality Commission regulations are kept under review.

Established governance arrangements maintain effective risk management arrangements across the Integrated Service Units (ISUs) maintain risk registers and report accordingly. The system directors for each of the ISUs are responsible and accountable to the Chief Operating Officer for the quality of the services they manage and to ensure that any identified risks are placed on the ISU risk register. All such risks are reviewed by the relevant ISU and any escalation as required is managed in accordance with the risk reporting process.

While the Chief Executive has overall responsibility for the management of risk, other members of the Executive team exercise lead responsibility for the specific types of risk as follows:

Strategic risk	***Chief Executive***
Clinical and quality risks	***Chief Nurse/Medical Director***
Financial risks	***Chief Finance Officer***
Workforce risks	***Chief People Officer***
Clinical staffing risks	***Chief Nurse/Medical Director***
Operational risks	***Chief Operating Officer***
Information management and technology risks	***Director of Transformation and Partnerships***

All Board level directors are responsible for ensuring there are appropriate arrangements and systems in place to identify and assess risks and hazards, comply with internal policies and procedures, and statutory and external requirements and integrate functional risk management systems and develop the assurance framework. These responsibilities are supported operationally by service unit managers.

All members of staff have responsibility for participation in the risk/patient safety management system, through:

- awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments
- compliance with all legislation relevant to their role, including information governance requirements set locally by the organisation
- following all our policies and procedures
- reporting all adverse incidents and near misses via our incident reporting system
- attending regular training as required ensuring safe working practices
- awareness of our patient safety and risk management strategy
- knowing their limitations and seeking advice and assistance in a timely manner when relevant.

We recognise the importance of supporting staff. ISU and directorate risk management activities are supported by a risk management training programme, principally delivered by the risk officer and monitored by the risk group, whose purpose is to provide a cross-organisational support network. Executive Directors and Non-Executive Directors are provided with risk management development on an individual basis or collectively at Board seminars.

We continue to maximise our opportunities to learn from other Foundation Trusts (particularly those who achieve outstanding CQC ratings), internal/external audit and continuous feedback is sought internally to ensure the systems and processes in place are fit for purpose. The findings are taken to the Quality and Assurance Committee to ensure that any learning points are implemented. A wider distribution of learning points for staff is disseminated via staff briefings and bulletins.

In addition to the organisation reviewing all internally driven reports, we adopt an open approach to the learning derived from third party investigations and audits, and/or external reports. We have also adopted a pro-active approach to seeking independent reviews should concerns be raised of a significant magnitude.

I have ensured that all risks of which I have become aware are reported to the Board of Directors. All new significant risks are escalated to the Executive Lead and reviewed and validated by the risk group. There is a regular programme of review of risks on the Board assurance framework by the Board of Directors, the purpose of which is to scan the horizon for emergent threats and opportunities, and consider the nature and timing of the response required to ensure the risk is kept under control.

The risk and control framework

Risk is managed at all levels of the organisation and is co-ordinated through an integrated governance framework consisting of a number of key groups that report on a regular basis to either the Quality Assurance Committee, People Committee, Finance, Performance and Digital Committee, Building a Better Future Committee or Audit Committee.

The key groups are: safeguarding / inclusion group, quality improvement group, serious adverse events group, people and education governance group, estate performance and compliance group, transformation and cost improvement programme group, finance delivery group, capital infrastructure and delivery group, information management and IT group, risk group, building a brighter future programme group and integrated governance group.

Our risk management strategy has defined our approach to risk throughout the year and provides an integrated framework for the identification and management of risks of all kinds, whether clinical, non-clinical, corporate, or financial and whether the impact is internal or external. This is supported by a Board assurance framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management. At each Board of Directors meeting, papers are provided with a report summary sheet through which directors identify links to one or more corporate objectives and one or more overarching corporate level risks / themes.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the risk management policy. Across a range of domains, the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. Our risk tolerance is defined as: ‘the amount of risk the Foundation Trust is prepared to accept, tolerate or be exposed to at any point in time’.

In setting a tolerance, it has been determined that any risks to the delivery of the organisation’s objectives with a current risk score of 15 or above will be brought through the exception reporting process via the risk group and Board Sub-Committees to the Board of Directors if deemed to be a corporate level risk. Actions and timescale for resolution are agreed and monitored. Such risks are deemed to be acceptable by the Executive Team only when there are adequate control mechanisms in place and a decision has been made that the risk has been managed as far as is reasonably practicable. Risks scored below this level are managed by the relevant lead director, service unit or directorate.

The risk group receives reports on any risks which could impact on our strategic objectives, particularly those risks deemed to be ‘major’ or ‘catastrophic’ or which could escalate to these levels if action is not taken. The risk group also oversees the development of our long-term strategy and implementation of the risk management and assurance framework. A deep dive schedule was established during the year which ensures that significant risks (current risk score of 15) receive detailed scrutiny at the risk group, Audit Committee, Quality Assurance Committee, People Committee, Building a Better Future Committee or Finance, Performance, and Digital Committee meetings. Further information can be found within our risk management policy.

Significant risks (any with a current risk score of 15 or more in accordance with the risk scoring matrix) will be reported to and considered by the risk group. If it is deemed that a risk is a ‘corporate level’ risk, it will be added to the corporate risk register as described in our risk management policy.

The risk group reviews the corporate risk register to ensure that:

- the risk has been appropriately assessed and recorded
- actions plans/points are in place and leads identified and timescales for delivery
- the risk and action points/plans are monitored to completion.

Risks posing a threat to our strategic objectives are escalated to the Board assurance framework.

The Executive Team is responsible for:

- ensuring that programme and operational risks are actively managed within their areas of the business
- being owner and action owner of individual risks (including those delegated by the Chief Executive)
- devising short, medium, and long-term strategies to tackle identified risk, including the production of any mitigating action plans.

The Audit Committee has responsibility for the review of governance, risk management and internal control covering both clinical and non-clinical areas. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management (including regular review of the Board assurance framework and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives. The Audit Committee will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Audit Committee may review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation and make recommendation to the Board of Directors where appropriate. Where the Audit Committee feels that there is evidence of ultra-vires transactions, evidence of improper acts or if there are other important matters that the Committee wishes to escalate, the Chair of the Audit Committee will raise these at a full meeting of the Board of Directors and, if appropriate, exceptionally to NHSEI. After each meeting, the Chair of each Committee is required to provide a summary report to the Board of Directors addressing ‘key issues’ and any ‘key decisions/recommendations.

The Board of Directors evaluates the Board assurance framework at each meeting with any exceptions being reported at other times of the year. Corporate level risks /

themes are included on all Board papers in relation to the action being taken to manage these risks.

An example of where risk management is incorporated into our core business is in relation to the integrated finance, performance, quality and people Board report. The monthly report to the Board of Directors provides commentary on performance and on key variances and improvements. The report is created by the outcomes and actions from various meetings, for example, the integrated governance group meetings and Executive team weekly meetings. Each of the Board Sub-Committees also reviews the section appropriate to scope of their work at each of their meetings, for example the People Committee receive the people section of the integrated Board report.

We ensure that public stakeholders are involved in managing risks which impact on them. The Council of Governors, having responsibility for representing our members and the public, receive briefings from the Chief Executive and Chair and have regular dialogue with the Chair, Executive Directors and Non-Executive Directors. Matters pertaining to our performance, both quality, financial and people-related, and any changes to our services are reported.

Discussions have also been ongoing throughout the year with commissioner colleagues to ensure all key access targets are being managed from within available resource. There have been regular contract management meetings with the our lead commissioners and councils.

Principal risks

Our risk management processes have identified a number of risks for 2021/22. These system-wide risks relating to unprecedented challenges as a consequence of the COVID-19 pandemic as well as achieving financial sustainability and controlling costs, while having sufficient monies to maintain the digital and estate infrastructure to ensure continued patient safety, quality and productivity have been considered and reflected in the Board assurance framework. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

The risks to the achievement of our strategic objectives are described in the Board assurance framework for 2021/22 as:

Strategic Objective 1: Improved wellbeing through partnerships
Principal Objective: To develop and implement the long-term plan with partners and local stakeholders to support the delivery of our strategy

- risk of failure to develop and implement the long-term plan with partners and local stakeholders to deliver our strategy
- risk of failure to implement our plans to transform services, using digital as an enabler, to meet the needs of our local population and the peninsula system

- risk of contracting of services with external drivers not being aligned
- risk in relation to securing agreement re clinical strategy and road map for Devon
- risk in relation to leadership and project capacity in ICS to lead development of system work programme capacity for COVID-19, redeployment to manage key positions, ensuring no unintended consequences
- risk of securing adequate resources to support pump priming of implementation plan, including infrastructure and digital

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

- risk of failure to ensure the development and implementation of robust recovery plans in response to the COVID-19 pandemic
- risk of failure to deliver levels of performance that are in line with our plans and national standards
- risk of failure to achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care
- risk of failure to provide safe, quality patient care and achieve best patient experience
- risk of failure to provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times
- risk of failure to provide and maintain a fit for purpose digital infrastructure ensuring service continuity at all times
- risk of failure to develop and implement the hospital infrastructure plan '*Building a Brighter Future'* ensuring it meets the needs of the local population.

Strategic Objective 3: Valuing our workforce
Principal Objective: To implement and continuously review the impact of our people plan ensuring we provide 'a great place to work'

- risk of failure to fully implement our people plan, ensuring we offer *'the best place to work'*
- risk in relation to supply, recruitment and retention of staff across specific specialties/professional groups
- risk in relation to information data/reporting to ISUs / lack of triangulation/timeliness
- risk of inadequate workforce capacity and resilience, burnout/fatigue arising from ongoing significant operational pressures
- risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
- risk in relation to turnover of leaders/managers.

Strategic Objective 4: Well-led
Principal Objective: To build patient, public and stakeholder confidence that their health and care is in safe hands

- risk of failure to ensure leadership capacity and capability to deliver high-quality sustainable care for the local population
- risk of failure to actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on our reputation.

Our corporate governance arrangements at Board and Board sub-committee level remained in place albeit with a focus at times on essential business and COVID-19 related issues. Another review of our scheme of delegation and standing financial instructions is in progress to allow authorisation of orders and invoices to be made at the appropriate level and in a timely manner. This is due to be presented to the Board for approval during Q1 2022/23.

The Board assurance framework and corporate risk register were both refreshed to include risks to our existing operational and strategic. As the pandemic continued through the year, the reporting and COVID-19 related reporting was absorbed in to business as usual activities.

Looking forward to 2022/23, it is anticipated that the risks as already identified in the Board assurance framework will continue in to the following year. Following the approval of our strategy in January 2022, there are plans to review the Board assurance framework so that it is aligned to the new strategic objectives.

Financial, performance, people and quality risks
As we go into 2022/23, plans are in place to mitigate these risks through rigorous control and management of significant productivity, efficiency, budgetary and operational improvements, as well as triangulation with people and quality risks. Outcomes will be measured by monthly review of financial, quality, performance and people information by the Board, in addition to scrutiny of the impact of efficiency savings on patient safety and quality of service.

The Quality Assurance Committee receives the outputs from the quality and safety impact assessments of the cost improvement plans from the Chief Nurse and Medical Director on an annual basis. Ongoing monitoring by the People Committee provides additional scrutiny of the impact and value arising from the Trust's People Plan.

A Board Sub-Committee focussing on finance and performance is in place to provide additional scrutiny of productivity and improve financial efficiency by reducing variation at directorate level. This will be achieved by benchmarking our operational efficiency against the Lord Carter Model Hospital metrics. Our plans, which are built up from integrated service unit level and system developments, have been revised to take account of the ongoing financial regime and the impacts of the COVID-19 pandemic. All planned efficiency schemes have been validated to reflect their prospects of delivery within the new financial framework and taking account of significant service and practice changes implemented as part of the COVID-19 response.

Prior to COVID-19 pandemic, we had developed an efficiency programme amounting to £18.6m or 3.7% of operating income. Since the start of the pandemic from March 2020, there had been significant changes in NHS financial planning and reporting regime. As a result of the pandemic and in line with national guidance, those schemes were put on hold, and the revised efficiency requirements in Half 1 (H1) and Half 2 (H2) planning periods in 21/22 have been either delivered or fully mitigated recurrently in-year.

We implemented a senior management-led governance groups (including transformation and cost improvement programme group) as part of our response to COVID-19, which has been the vehicle through which efficiency programmes were re-launched, managed as well as supported by external partners. Cost improvement programme delivery does however remain a significant challenge as we move in to 2022/23 with changes to NHS financial regime, and is reflected as such in the corporate risk register and the Board assurance framework.

Capital funding risks

While the COVID-19 regime allowed us to report a modest surplus in 2021/22, reduced levels of underlying EBITDA associated with challenged financial performance, have significantly restricted the level of cash available for capital expenditure in recent years. The consequence is seen in an increased backlog in essential repairs and replacements across all areas of expenditure, estates, information management and technology and medical equipment. The ability to invest in developmental capital necessary to further develop our care model has, similarly been curtailed.

Nevertheless, we have access to significant amounts of national funding which will mitigate the shortfall in internally generated cash. We are further developing further sources of finance through ongoing negotiation with NHSEI that will enable this risk to be addressed, including: a strategic estates partnership, lease options, bidding, largely through ICS processes for public dividend capital and, where appropriate and subject to the necessary approvals, debt financing (loans).

System cost pressures

The pressure in the 2021/22 cost base reflects the increasing operational risk profile across our organisation, including the costs of addressing the consequences of infrastructure failures, targeted investment in safer staffing and continued reliance on in-sourcing and out-sourcing of elective and diagnostic services to recover performance against national targets. We continue to rely on agency medical and nursing staff in a number of shortage areas. Uniquely, and most significantly in our organisation, are pressures building in continuing health care and adult social care. This is largely the result of a number of providers withdrawing from the market or experiencing difficulty in maintaining qualified staffing, restricting the number of placements available. As we look forward to 2022/23, rising inflation will be a significant risk to market sustainability in the residential and nursing care sector.

The ICS for Devon system-wide plans for 2022/23 have been developed in conjunction with our partners and through the Board. These have been tested by a peer review process organised by the ICS for Devon and scrutinised by the regulator. The Board has acknowledged that we must continue to develop our planning and delivery models, and to this end we are implementing a revised operational structure, which both respects our geographical spread and diversity while grouping services (through care groups) where there is greatest clinical synergy in doing so. An enhanced accountability framework and programme management office supports this model.

Despite achieving financial balance in 2021/22, the financial outlook is challenging and there is significant risk to achieving the necessary level of financial improvement within our organisation and across the ICS for Devon.

Operational planning and activity risks

As we look ahead to the next 12 months there are ongoing risks associated from the continued impact from COVID-19 alongside our actions to step back up elective activity levels.

The action to increase elective activity is essential as the risks to patients waiting requires us to achieve a reduction in elective waiting times. These waiting times have continued to increase over the last 12 months, while the level of urgent care demand and wider system pressures associated with COVID-19 have not reduced.

We are required to maintain a level of COVID-19 capacity and will continue to work closely with system partners to mitigate the capacity risk. These risks are significant in the staffing capacity available to our independent sector partners in the care home sector. The impact of these pressures are illustrated in the increased number of patients in hospital settings of care when they are medically fit for discharge and limits capacity for new admissions resulting in ambulance and emergency department delays. This has been a particular challenge throughout the most recent wave of Omicron infections with widespread community infections impacting of staffing and demand on services.

We are responding to the challenges set out with further service changes to increase elective capacity through protected elective beds and return of the day surgery theatres from the COVID-19 escalation response. We will also retain enhanced capacity for the acute emergency pathway for assessment and bed-based care when needed while optimising the opportunities with the care home and domiciliary care sector.

In October 2022, the new Acute Medical Unit (AMU) will open, this being the result of a £15m capital investment and 18-month building programme. This will bring together medical teams along with the assessment space needed to optimise the delivery of same day emergency care (SDEC), with onward admission only for patients requiring overnight hospital stay.

The avoidance of clinical harm for patients experiencing long waits or requiring rapid access through urgent and cancer pathways is an increasing risk. Reducing these waits is a current and on-going priority and we will ensure clinical prioritisation of patients is a key priority. To give assurance we are implementing programmes of clinical and non-clinical validation and as well as accessing additional funding to increase activity through the elective recovery fund (ERF).

We will continue to adopt new ways of working and clinical pathways to meet these challenges. This is a great opportunity in many ways to positively embrace change and will include virtual consultations for outpatient appointments. These appointments are already being favoured by many patients, flexible use of day case and inpatient theatres with transition to outpatient treatments where possible.

This will be another very challenging year in returning to higher levels of elective activity and maintaining emergency services with COVID-19 being present in terms of requiring ongoing infection prevention and control and demand on hospital and wider system capacity.

Elective Waiting time: During 2022-23 the Trust will start to see improvement in waiting times in line with National priorities. The target is to have all waits of over 78 weeks treated by 31st March 2023. Operational plans are in place to support the reduction in waiting times through the full operational recovery of elective capacity of the day surgery unit and protected elective beds for patients requiring inpatient admission. The Trust is also creating additional capacity funded through the Elective Recovery Fund (ERF) to include utilising theatres at weekends and support from insourcing additional clinical capacity.

Elective Waiting time data quality accuracy: To ensure the accuracy of waiting lists the trust has a validation programme and access to ongoing training to ensure all waiting lists are accurate and reflect adherence to the National RTT rules. The trust has an operational Patient Target List (PTL) that is published to all teams and updated daily. Over the last few years the Trust has received external review of its waiting list processes and governance.

All long wait pathways (currently those over 52 weeks) are routinely validated by an independent RTT analyst – any inaccuracies in the technical application of RTT rules are corrected and fed back to the operational teams. All additions to the Inpatient / daycase treatment waiting list are clinically prioritised with the application of the National “P” codes. Booking of patients is done within chronological order and reasonable offer dates taking into account clinical prioritisation and service capacity.

Care Quality Commission (CQC)

The Chief Nurse is responsible for ensuring compliance with our registration with the CQC. This is achieved by:

- reporting and keeping under review matters highlighted within inspections

- liaising with the CQC inspectors and senior clinicians and managers in response to any specific concerns raised by the CQC by patients and members of the public
- engaging with the CQC inspectors in the inspection process and co-ordinating our response to inspections and any recommendations or actions that arise
- analysing trends from incident reporting, complaints and patient and staff surveys and sharing the learning from these across our services
- reviewing assurances on the effective operation of controls
- receiving assurances provides by internal audit and any clinical audit conclusions, which provide only limited assurance.

In December 2021, the CQC undertook a focused inspection of medical care core services and issued the following improvement requirements:

- ensure risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with our policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h))
- ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)).
- ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).

We have developed a comprehensive action plan to ensure full compliance with the improvement notices within the stipulated timescales.

Care Quality Commission compliance declaration

At 31 March 2022, we remain fully compliant with the registration requirements of the CQC.

Compliance with NHS Foundation Trust condition 4(8)(b)

The assurance process described in this statement allow the Board to issue an accurate Corporate Governance Statement, required under NHS Foundation Trust condition 4(8)(b) of NHS Improvement's provider licence.

We used the learning from the most recent CQC Well Led and NHS Improvement Use of Resources inspections to form the basis of the externally led assessment developmental review of leadership and governance using the NHS Improvement well-led framework that took place in Q3 2020/21.

Communication with stakeholders

Our communications team works in partnership with the feedback and engagement team and the membership office to ensure that there are sufficient and robust mechanisms in place to inform the public about, and involve them in, our work.

Together we are committed to ensuring that patients, carers, staff and the public are listened to and have the opportunity to feedback on their experiences while also

raising concerns and asking questions about any of our current and future activities. We work closely with our partners in the Integrated Care System for Devon (ICSD) and any formal consultation is led by the ICSD with our support and involvement as appropriate.

This year we have undertaken public engagement in Dartmouth with the support of Healthwatch on the redevelopment of the former community hospital site and supported the ICSD with focused engagement on protective elective care.

The Board of Directors approved our new engagement and communications strategy in September 2021 which is shaping our approach to public engagement and involvement. We have begun to co-produce our patient and service user experience of health and care strategy with key stakeholders to ensure we can hear and learn better from patient and carer experiences,

A number of forums exist that allow the Board of Directors, Executive Directors and staff at all level to communicate with key stakeholders, including formal Board to Board and Executive to Executive meetings with local commissioners, local health and care providers, Health and Wellbeing Boards, Health Overview and Scrutiny Committees with our local authorities and regular meetings with local MPs and Healthwatch. These forums, supported by our other communications, engagement and feedback channels, provide a mechanism for any risks identified by stakeholders that affect us to be discussed for any action plans to be developed.

Compliance with people strategies and 'developing workforce safeguards'

We have processes to ensure that short, medium and long-term people strategies and people systems are in place to assure the Board that people processes are safe, sustainable and effective. Further, as part of the safe staffing review, the Chief Nurse and Medical Director confirm that staffing is safe, effective and sustainable and meet the requirements of the National Quality Board and the Workforce Safeguards Guidance (NHSI 2018).

The Board continually reviews the effectiveness of its systems of internal control. The embedding of the strengthened governance framework supports the provision of evidenced based assurance from ward to Board. The Board reviews the organisation's performance in the key areas of finance, activity, national targets, patient safety and quality and people in the form of an integrated quality dashboard. This includes the regular presentation of performance information against key quality, people and financial metrics to the Board and its Committees. The people section contains information on monthly staff sickness, staff turnover and volume of temporary staffing, as well as performance against the annual staff survey. These are high level organisational metrics and data that we will continue to collate, review and analyse each month for a range of people metrics, quality and outcomes indicators and productivity measures.

Our people operating model mirrors that of our care model, helping to enable and empower teams to be self-organising. In embedding our aim to be a fully integrated organisation providing integrated pathways of care, a system leadership structure has been established that will oversee the entire pathway of care across primary and community care, through to emergency medicine and planned care. While, the new structure continues to embed, a culture has evolved fostered around autonomy and accountability with a common sense of purpose with an overall aim to support and engage staff and ensure their time is used in the best way possible to provide direct or relevant care or care support.

We seek to continuously improve our performance against workforce standards and the national staff survey. Our people plan and promise forms part of our annual plan sets out the key organisational aims for the coming year, including how we will maximise people analytics, planning and redesign capabilities. In terms of the wider context, we remain fully engaged with the Devon system workforce strategy, of which the main focus of the people planning and transformation plan will be centred on developing a culture and structure that facilitates trust, involvement and innovation and local empowered decision making.

Compliance with 'Managing Conflicts of Interest in the NHS' guidance

We have published on our website, an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by us with reference to the guidance) within the past 12 months as required by the '*Managing Conflicts of Interest in the NHS*' guidance published by NHS England.

Compliance with NHS pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Compliance with Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

We are committed to providing an inclusive and welcoming environment for our patients, clients, service users, carer, families and staff, and we are working hard to mainstream diversity, inclusion and human rights into our culture.

A range of control measures are in place to ensure the organisation complies with its obligations under equality, diversity and human rights legislation. Performance is monitored via two core streams: the equality co-operative (public) which consists of equality leads from Devon across health, social care, Local Authorities and the Police. The Equality Business Forum (for staff) which consists of leads and

representatives of our network groups as well as a Staff Side representative, which reports through the newly formed People Committee.

The Board of Directors receives reports on diversity and inclusion issues from the Chief Nurse (patient and service user updates) and the Chief People Officer (people updates). These include any updates or changes in national mandates together with any risks or challenges. The Board has been appraised of the latest developments in relation to publication of the RACE Equality Code 2020 and held a Board development session focussing on equality, diversity and inclusion in Q1 2021/22.

Compliance with Climate Change Act and the adaptation reporting requirements

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and the adaptation reporting requirements are complied with and in line with NHS net zero targets.

Review of economy, efficiency, effectiveness, and use of resources

Directors are responsible for putting in place proper arrangements to secure economy, efficiency, and effectiveness in our use of resources. We have established several processes to ensure the achievement of this. These include:

- clear processes for setting, agreeing, and implementing strategic objectives based on the needs of the local population, reflecting the priorities of key partners and the Department of Health and Social Care. This includes a clear strategy for patient, client, service users, carers, and public involvement as well as our public members, providing a key focus for our engagement work within Torbay and South Devon. Established objectives are supported by quantifiable and measurable outcomes
- clear and effective arrangements for monitoring and reviewing performance which include a comprehensive and integrated performance dashboard used monthly in the performance management of health and social care services and reported to the Board of Directors. The integrated finance, performance, quality and people report details any variances in planned performance and key actions to resolve them, plus the implementation in a timely fashion of any external recommendations for improvement, for example, external audit
- there is also a performance management regime embedded throughout the organisation including weekly capacity review meetings, financial recovery planning meetings, executive reviews of services, budget reviews (undertaken monthly) and regular work to ensure data quality
- Committees consider reports of external regulators and bodies, with improvement action plans developed and their implementation monitored where and as necessary
- through the Finance, Performance and Digital Committee, we have arrangements for planning and managing financial and other resources in place. These are encompassed in the Scheme of Delegation and the Standing Financial Instructions which receive regular audit review

- we use other benchmarking tools such as the Model Hospital productivity metrics to demonstrate the delivery of value for money. We continue to develop its reference cost reporting data to ensure services are being provided as efficiently as possible. For procurement of non-pay related items, we have a clear procurement strategy and collaborates with other NHS bodies to maximise value through the NHS south west peninsular procurement alliance.

Compliance with information governance requirements

Improving information governance is a key priority for us. This is reflected in our commitment to the national standards set out in the Data Security and Protection Toolkit (DSPT) which we are required to complete and submit every year.

Completion of DSPT demonstrates that we are compliant with the following:

- General Data Protection Regulation (GDPR)
- compliance with the expected data security standards for health and social care for holding, processing or sharing personal data
- readiness to access secure health and care digital methods of information sharing, such as NHS mail and Summary Care Records
- good data security to the CQC as part of the Key lines of Enquiry (KLOEs).

We have appointed into key roles to support our commitment to data protection by design and default. These roles are the champions of appropriate data capture, processing, security and sharing by the organisation

- **Senior Information Risk Owner (SIRO), Executive Director of Transformation and Partnerships** is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level
- **Caldicott Guardian, Medical Director** is the senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
- **Data Protection Officer (DPO)** is the independent expert in data protection and reports to the most senior levels within the organisation on risks to the privacy of individuals.

We welcomed the Information Commissioner's Audit team in their assessment of our compliance with UK GDPR and Data Protection legislation. The audit report confirmed a high level of assurance in regards to governance and accountability and a reasonable level of assurance for data sharing. We welcomed the actions from the report.

The Data Security and Protection Toolkit is supplied by NHS Digital to support the performance monitoring of Information Governance within the NHS and to evidence organisations are compliant. We have submitted 'standards met' and also the current baseline assessment.

Information Governance risks are recorded on our risk management system. These are monitored by the Head of Information Governance for guidance and support in

resolution. Summary reports and highlighted risks are discussed at information governance steering group chaired by the SIRO.

New projects require a data protection impact assessment which endeavour to highlight, and therefore mitigate, potential Information security risks. New technology and Artificial Intelligence use are recorded and monitored by the information governance team.

We are committed to a culture of openness and transparency as evidenced in the wide reporting of incidents. Incidents involving a breach of confidentiality are recorded on our incident reporting system, are assessed but the information governance team and summary reports are presented to the information governance steering group, as a sub group of the information management and technology group

We are committed to the support of home working in the government's response to the COVID-19 pandemic with the organisation implementing safe agile working practices for staff including working from home guidance, direct access rollout and fast track provision of equipment and technology. Nationally procured systems for patient management were assessed and implemented locally including virtual clinics. New data collections in regards to COVID-19 have been managed and shared in line with UK GDPR and national guidance including Control of Patient Information (COPI)

Data Quality and Governance

From 01 April 2021, responsibility for information transferred to the Director of Transformation and Partnerships. The Medical Director and Chief Nurse hold executive leadership for patient safety, ensuring the quality of care delivered within our organisation is of the highest standard.

There is a clear structure from ward to Board to ensure the quality of care is maintained and that information is both timely, accurate and shared appropriately to improve the quality of care provided. Staff are taught and supported in doing root cause analysis and after-action reviews by the ISU clinical governance coordinators.

Performance dashboards are used across the organisational governance structure to give monthly oversight of key metrics covering quality, workforce, performance and finance. Each of the specialist areas has its own processes for assurance on data quality and reporting accuracy.

We have implemented the recommendations from the commissioned Price Waterhouse Coopers review of data quality that was undertaken in the previous year as part of the annual plan assurance process.

Clinical protocols are published and updated with the specialities and equality impact assessments are undertaken when services change. The Chief Nurse and Medical Director run monthly clinical audit and effectiveness group meetings to review and recommend implementation of local and national evidence (NICE guidance, national audits etc.) Across the specialities, clinical effectiveness meetings run monthly or bi-monthly with the aim of sharing learning and outcome data.

With regard to NHSEI performance indicators, these are reported monthly to the Board as part of the integrated performance report.

Operational controls are maintained with Chief Operating Officer oversight through fortnightly performance risk and assurance meetings with service leads. Performance benchmarking including model hospital and third-party benchmarking including Dr Foster, 'Gooroo' Planner (referral to treatment data ('RTT')) and NHSEI performance benchmarking is used to triangulate data and support assurance of data quality and reporting accuracy.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and its sub-committees: including the Audit Committee; Quality Assurance Committee; Finance, Performance, and Digital Committee; Building a Brighter Future Committee and People Committee, and in addition the Executive Group and risk group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its corporate objectives have been reviewed. My review has also been informed by the major sources of assurance on which reliance has been placed during the year. These sources include reviews carried out by our external auditor Grant Thornton LLP, Deloitte LLP, Care Quality Commission, Internal Audit, NHS Resolution and the Health and Safety Executive.

The following Committees and groups are involved in maintaining and reviewing the effectiveness of the system of internal control:

- the Board of Directors has overall accountability for the governance arrangements, including the committee structure, and ensuring we adhere to our constitution and apply our standing orders, scheme of delegation and standing financial instructions correctly. The Chairs of each of the Board sub-committees present a report to the next available Board meeting for the purpose of providing assurance on matters within its terms of reference. Urgent matters if requiring escalation to the Board are reported by the Committee Chair in the intervening period. The Board has agreed, in conjunction with the Council of Governors, the strategic objectives for the organisation. The Executive Directors have assessed

the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in our Board assurance framework document reviewed regularly by the Board of Directors;

- the Audit Committee is responsible for establishing an effective system of internal control and risk management and provides an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity by reviewing the statement on internal effectiveness and Annual Governance Statement. Reports from the internal auditors and external auditor also provide assurance. The Committee also reviews on a regular basis, the risks that are described in the Board assurance framework. The Committee has oversight of, and relies on the work of the risk group to monitor the risk management process and risk registers. The Committee has oversight of expressions of concerns and whistleblowing arrangements. The Audit Committee is chaired by the Vice-Chair and membership comprises the Chairs of each of the Board Sub-Committees;
- the Quality Assurance Committee provides the Board of Directors with assurances of clinical effectiveness through scrutiny of patient quality and safety, patient experience, medicines management and staffing. It monitors selected quality metrics and ensures the organisation has robust systems in place to learn from experience. It receives reports from specialist governance groups e.g. safeguarding; patient safety; and serious incidents and undertakes a deep-dive review into a service or specialty at each meeting. The Quality Assurance Committee is chaired by a Non-Executive Director and reports to the Board of Directors;
- the Finance, Performance and Digital Committee oversees, co-ordinates, reviews and assesses our financial, performance and digital management arrangements, including monitoring the delivery of the NHS long-term plan and supporting annual plan decisions on investment and business cases. The Committee provides the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on our financial viability and sustainability. It provides detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board of Directors. It also assesses and identifies risks within the finance, performance and digital portfolio and escalates as appropriate. The Finance, Performance and Digital Committee is chaired by a Non-Executive Director and reports to the Board of Directors;
- the Building a Brighter Future Committee was established in 2020 for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital programme and to support the successful achievement of the programme's investment objectives and realisation of the stated benefits. It also aims to assure the Board of the achievement of the objectives set out in the programme, that approved projects are being effectively managed and controlled and confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable;
- the risk group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the risk management strategy. It promotes effective risk management and compliance and supports maintaining a dynamic Board assurance framework and risk management database where risks are registered. It also ensures local level

responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of our activity where robust controls are not evident in order to raise standards and ensure continuous improvement. The risk group is chaired by the Chief Finance Officer.

The internal audit reports issued in the year have given significant assurance that there is generally a sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently. Some weaknesses in the design and/or inconsistent application of controls which put the achievement of certain objectives at risk are appropriately managed.

Internal audit undertook 13 substantive reviews and a high-level assessment of the Trust's governance arrangements to inform the Head of Internal Audit Opinion for 2021/22. Internal audit reports are received by the Risk Group for review and action and are presented to the Audit Committee for assurance. Action plans and progress are reported in detail to each subsequent Audit Committee meeting as part of internal audit's follow-up process. This process includes a programme of review of improvements in practice in response to limited assurance reviews by the Audit Committee, including presentation of the action plan to the Audit Committee by the Executive Lead Director. The internal auditor takes a risk-based approach to formulating the annual work plan for agreement with management prior to final approval by the Audit Committee.

External audit provides independent assurance on the Annual Accounts, Annual Report and the Annual Governance Statement.

Conclusion

In concluding my review on the overall system of internal control, I am assured that:

- the Board, Executive Directors, senior management and staff of the organisation, have identified and are managing the risks we face, with escalation of risk events, an effective process for keeping risk scores up to date and flagging any risk and control concerns;
- there is an appropriate risk management framework embedded in the organisation along with there being no major concerns from the undertaking of an effective programme of independent, risk-based monitoring; and
- our internal auditors and other independent assurance providers such as external auditors, have no major concerns from their risk focussed programme of independent assurance.

My review therefore confirms that no significant internal control issues have been identified for the financial year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Liz Davenport, Chief Executive
21 June 2022

Statement of directors' responsibilities in respect of the accounts of Torbay and South Devon NHS Foundation Trust

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

Liz Davenport, Chief Executive
21 June 2022

David Stacey, Chief Finance Officer
21 June 202

Appendix A – Biographies of the Board of Directors as at 31 March 2022

Richard Ibbotson – Chairman **Appointed:** June 2014 **Reappointed:** April 2017, June 2020, June 2021 and March 2022	Sir Richard Ibbotson was appointed as Chairman in June 2014, shortly after retiring from a career in the Royal Navy. This included periods in command of Britannia Royal Naval College Dartmouth, Commander British Forces Falkland Islands and Deputy Commander-in-Chief Fleet (effectively Chief Operating Officer of the Royal Navy and Royal Marines). He has considerable experience in operating at Board level and dealing with operational pressures and challenging budgets. As well as being knighted for his services, Richard is a Companion of the Most Honourable Order of the Bath and holds the Distinguished Service Cross and the NATO meritorious service medal. His academic background includes a degree in chemistry, a master's degree in defence technology, and an honorary doctorate in technology. He also holds other public roles, notably as a Deputy Lord Lieutenant for Devon. Richard has been a Governor of Plymouth University and Chairman of the Royal Navy Royal Marines Charity and was a Member of the Armed Forces Pay Review Body. Richard is Chair of the Non-Executive Nominations and Remuneration Committee and the governor Nominations and Remuneration Committee.

Liz Davenport – Chief Executive **Appointed:** October 2018	Liz as Chief Executive is responsible for the overall management of the organisation's activities delivering high quality services to the standards set within the resources available. As Accountable Officer she is responsible for ensuring that the organisation meets all of its statutory duties. Liz joined Torbay and South Devon in September 2014 and was appointed as the Chief Operating Officer in January 2015. She took a key role in leading the implementation of the integrated care model, including the development of community services. Liz was appointed in October 2018 as the substantive Chief Executive following a period in the interim role. Liz has a clinical background, and has been employed in the NHS since qualifying in 1986 as an Occupational Therapist. She has a passion for service improvement and transformation designed to improve outcomes and experiences for people in our communities making the best

	use of resources and evidence of what works well. Her career started in mental health services where she was involved in the setting up of community services for people with mental health needs. She has subsequently continued to work in a number of NHS organisations across the country leading on a number of service improvement projects in mental health, learning disabilities and social care services. She has also held a broad portfolio of Executive Director positions including Director of Operations, Director of Workforce and Organisation and Deputy Chief Executive in Devon Partnership Trust before making the transition to acute and community services in Torbay.
Chris Balch – Non-Executive Director **Appointed:** April 2019	Chris Balch joined the Board as Non-Executive Director in April 2019. Chris is Emeritus Professor of Planning at Plymouth University and is a Chartered Town Planner and Surveyor. Prior to his academic career he held senior executive positions with an international property advisory company, latterly as Managing Director of DTZ UK & Ireland, now part of Cushman & Wakefield. He has extensive experience of providing consultancy advice to public and private sector clients across the UK and overseas specialising in the planning and delivery of major regeneration projects and programmes. He was Chair of Basildon Renaissance Partnership, a member of the Council of Essex University, a Director of Torbay Development Agency and was until 2017, Non-Executive Chairman of Hilson Moran, a consultancy specialising in the energy performance of complex buildings. He is currently a member of the Supervisory Board of Ecorys BV, a European policy and research consultancy and is a Trustee of South West Lakes Trust. His interest lies in tackling the underperformance of places and managing positive change within professional organisations and communities. Chris is Chair of the Building a Brighter Future Committee (previously known as the HIP2 Redevelopment Committee). He is also a Board member of our subsidiary SDH Innovations Partnership LLP.

Jacqui Lyttle – Non-Executive Director and Senior Independent Director **Appointed:** October 2014 **Reappointed:** October 2017 and October 2020	Jacqui Lyttle joined the Board as a Non-Executive Director in October 2014 having spent over 20 years working in the NHS at very senior manager and executive board level before establishing her own healthcare consultancy in 2008. She has a genuine passion for improving care for patients and speaks both nationally and internationally on quality and service improvement, commissioning for outcomes and the management of change within healthcare. Jacqui has an interest in the management of pain and is an executive member of the Chronic Pain Policy Coalition a standing committee of an all Parliamentary Party Advisory Group. Other areas of interest include rheumatology, dermatology, endocrinology, cardiology and oncology with Jacqui working extensively in these areas across the UK Jacqui continues to work actively within the NHS, undertaking service reviews and leading on large scale quality improvement programmes and acts as an executive commissioning advisor to several Royal Colleges and health related charities including Action on Pulmonary Fibrosis, Neuroendocrine Cancer UK and Diabetes UK. Jacqui is a lecturer on the NHS for Health Education England and has a keen interest in developing future clinical leaders. She is also an NHS advisor to several professional bodies including the British Society for Rheumatology and the British Association of Dermatology. Jacqui is Chair of AGE UK Torbay. Jacqui is Chair of the Quality Assurance Committee and the Torbay and South Devon NHS Charitable Funds Committee and is the Senior Independent Director.

Vikki Matthews – Non-Executive Director **Appointed:** December 2017 **Reappointed:** December 2020	Vikki Matthews joined the Board as Non-Executive Director in December 2017. She is currently the Director for People and Culture at Health Education England, prior to which she ran her own coaching and consulting business. She was also the Chief Talent Officer for Plymouth University and held several Global and EMEA-wide Director level roles for Nike based in Holland and the USA. Vikki Chaired a Multi Academy Trust based in Plymouth from 2012-2017 and is currently the Company Secretary for a small education charity in Brighton. Vikki is Chair of the People Committee

Paul Richards – Non-Executive Director **Appointed:** November 2017 **Reappointed:** November 2020	Paul Richards joined the Board as a Non-Executive Director in November 2017. In the early part of his career, he spent many years working in the NHS at senior manager and Board level leading on Resource Management, Informatics, computing, and the digital transformation agenda. He has significant experience of clinical systems and electronic patient records ('EPR') programmes across all care settings. Paul has gone on to enjoy a long career in the Health Tech and IT industry and has led a variety of successful, well-known, international consulting, product, and services businesses at Board level. He has led large teams, with business and people across several continents, giving him extensive experience of a range of health and care systems. He has successfully turned around and grown several businesses in Health and Care and has been involved in a wide range of merger, acquisition, and divestment work. Paul has a passion for improving and connecting health and social care to improve the patient and service user experience. He continues to have a variety of business interests. Paul is Chair of the Finance, Performance and Digital Committee and a member of the Torbay Pharmaceuticals Board and the Building a Brighter Future and Audit Committees.

Robin Sutton – Non-Executive Director **Appointed:** May 2016 **Reappointed:** May 2019	Robin Sutton joined the Board as Non-Executive Director in May 2016. Robin is a chartered accountant with over thirty years of financial experience gained at a senior level for both private and public enterprises in both executive and Non-Executive Director roles. Robin has previously held Non-Executive Director and senior positions at several multi-national organisations including Sifam, JDS Uniphase, CompAir Holman, Rolls-Royce PLC and Deloittes. Robin's interest in healthcare stems from a variety of different factors, ranging from consulting for Lowell General Hospital in Massachusetts through to working with Novartis in developing ultrafast fibre laser technology for eye surgery. He has also been heavily involved with care services and social care covering a spectrum of services from meals on wheels, day care, supported living and residential care. Robin currently has local business interests in the care home industry and is the Chair of Devon Care Homes Collaborative. Robin has also enjoyed completing an Innovating in Healthcare program with Harvard University with a team of like-minded people looking at smart phone applications in the field of dementia. Robin is Chair of Torbay Pharmaceuticals and a Director of our subsidiary SDH Developments Limited.

Sally Taylor – Non-Executive Director and Vice Chair **Appointed:** January 2013 (South Devon Healthcare NHSFT) **Reappointed:** January 2016 and January 2019	Sally Taylor joined the Board in 2015 when we became Torbay and South Devon NHS Foundation Trusthaving previously been a Non-Executive Director of South Devon Healthcare NHS Foundation Trust from January 2013. Sally was appointed Chair of Cornwall Care Limited in January 2021. She was the Chief Executive of St Luke's Hospice in Plymouth from 1994 to 2016. St Luke's delivers specialist palliative care, including advice and support to other professionals, for patients in Derriford, at home and in the hospice in-patient unit. Prior to that she spent nine years as a Chartered Accountant with PricewaterhouseCoopers LLP in London, specialising in corporate finance for small and growing businesses. Sally has been Trustee/ treasurer/chairman of several charities including Hospice UK (the national membership body for hospices), the Harbour Centre drug and alcohol advisory service and the Barbican Theatre in Plymouth. Sally is Chair of the Audit Committee.

Ian Currie – Executive Medical Director **Appointed:** September 2020	Ian is responsible for provision of high quality, safe and effective care and providing medical input into shaping strategy as well as the Caldicott Guardian for the Trust. Ian joined Torbay Hospital in 1998 as Consultant Vascular Surgeon, having previously been Senior Registrar in General and Vascular Surgery at Plymouth Hospitals NHS Trust. Prior to this, Ian worked at several hospitals in the South West, including Cheltenham General Hospital, Bristol Hospitals, Gloucestershire Royal Hospital, as well as John Radcliffe Hospital in Oxford. This period also included a year spent working in Sydney, Australia. Ian has a long-standing interest in integrated care models, urgent and emergency care and elective care, and has held a range of appointments in educational and leadership roles throughout his career. He has a strong interest in prevention and previously developed and led the South Devon and Exeter Abdominal Aortic Aneurysm screening programme.

Judy Falcão – Chief People Officer (previously Director of Workforce and Organisational Development) **Appointed:** August 2016	Judy Falcão is responsible for the delivery of our people plan. Her key areas of responsibility cover services and functions including the resourcing hub, people hub (employee relations advisory services), business partnering, payroll and pensions, workforce information and planning, health and wellbeing including occupational health, organisational development including staff experience, leadership development, coaching, cultural change, talent management, equality and diversity and Freedom to Speak Up. Judy joined us in August 2016. Prior to joining the Trust, she was the Director of Workforce and Organisational Development at Poole Hospital NHS Foundation Trust. Judy has held several Executive Director roles across the NHS including Acute, Mental Health, Health Authority, and the Ambulance Service.

John Harrison – Chief Operating Officer **Appointed** April 2019	John Harrison is responsible for developing, implementing and ongoing oversight of health and social care delivery for our population. John joined us in February 2012 and in January 2018 took on the operations portfolio as Interim Chief Operating Officer, having previously been Deputy Chief Operating Officer. He was appointed to the substantive Chief Operating Officer position in April 2019. Prior to joining us, John was Director of the Peninsula Cancer Network and led the process across Devon and Cornwall to secure necessary service changes to deliver the NHS Cancer Plan improvements. He has 25 years of healthcare experience and was previously Director of Commissioning for Plymouth Primary Care Trust, having run GP Fundholding for the previous Health Authority. John's external interests include acting as a Trustee of SPACE Youth Service for Devon.

Adel Jones – Director of Transformation and Partnerships **Appointed:** July 2019	Adel has the responsibility to develop our organisational strategy and the delivery of key strategic ambitions, including being the Senior Responsible Officer for our New Hospital Programme (Building a Brighter Future), the delivery of our digital transformation strategy and leading the improvement and innovation team to deliver large scale transformation programmes. How we work collaboratively, in partnership with local health and care organisations, our local care partnerships, our staff and local people to deliver our new models of care is integral to this transformation. Adel leads the communications, engagement and partnerships portfolio and is responsible for developing strategic partnerships to ensure we meet the needs of local people. Adel has significant experience of large-scale transformational change across health and social care, developing new models of acute and emergency care, integrating health and care services in the community and driving operational efficiency through new ways of working. With extensive experience in strategic planning, workforce re-design, quality improvement and operational management, Adel has worked across many sectors over the last 25 years, including primary care, strategic health authority, acute and community health and care services. Before joining us in 2019, Adel was the Integration Director at the Royal Devon and Exeter Hospital. In leading the digital portfolio, Adel has a keen interest in digital innovation and is joint chair of the NHS Providers Digital Boards Programme.

Deborah Kelly – Chief Nurse **Appointed:** August 2020	Deborah Kelly is responsible for the quality and safety of the care we provide. Deborah joined us in August 2020 and as Chief Nurse leads on several objectives including quality, professional practice, patient experience, safeguarding, infection prevention and control, and clinical governance. Deborah qualified as a nurse in 1985 and has spent the majority of her career working in London in a range of leadership roles in community, acute and tertiary services. Deborah was previously Deputy Chief Nurse for Barts Health NHS Trust and more recently returned from working in the Middle East as the Deputy Chief Nurse and Chief Nurse for Informatics at Sidra Medicine, Doha Qatar. In her previous roles she has devised quality, clinical governance and patient experience strategies, ensuring that staff and patients voice are heard. Deborah feel passionately around creating opportunities to empower staff and has successfully introduced models of shared governance, enabling staff led change and improvement. Her work around patient and public engagement was cited as best practice internationally by the Canadian Agency for Drugs and Technologies in Health 2017 and she has successfully partnered with the Kings Fund in 2015/16 through the Collaborative Pairs Programme.

David Stacey – Chief Finance Officer & Deputy CEO **Appointed:** January 2020 (CFO) July 2021 (DCEO)	Dave Stacey is responsible for our financial planning and performance. He is also the Deputy Chief Executive. Dave joined us in January 2020 from North Middlesex University Hospital, where he spent three years as Director of Finance leading a successful financial turnaround, securing significant external funding for large capital programmes and overseeing a major digital transformation programme. His previous roles include Deputy Director of Transformation at Chelsea and Westminster NHS FT, where he played a pivotal role in the successful integration of West Middlesex Hospital, and Director of Strategy at England's biggest mental health trust, West London Mental Health. Prior to joining the NHS in 2013, he spent 7 years in KPMG's healthcare team, delivering audit and advisory services to a range of UK and international healthcare organisations.

Joanne Watson – Health and Care Strategy Director	Joanne is responsible for delivering our health and care strategy which focuses on making sure our services meet the current and future needs of our people while supporting them to live well. Her unique Board-level position showcases our innovative approach to providing integrated care and ensuring the best use of the monies we will receive from the Government's New Hospital Programme. We are proud to be one of only 40 recipients of this once in a generation programme which will support us to make a real difference in how we deliver services with, to and for our people. Joanne is also the Director of Infection Prevention & Control. Taking on this role in June 2020, near the start of the COVID-19 pandemic has required flexibility and the need to make decisions on limited information/ evidence. Our results and outcomes to date compare favourably to the national picture. Joanne joined us in 2016 as Deputy Medical Director and Consultant Physician in Acute Medicine. She is an accomplished medical leader with extensive strategic and operational experience which she has gained over many years as a senior clinician in a range of organisational and system leadership roles. Joanne held a twelve months fellowship working at the world leading Institute for Healthcare Improvement using quality improvement skills gained there in her daily work. She has been instrumental in areas of national policy such as the central role of patient experience and improvement in maternity services. Joanne qualified as a doctor in 1991, graduating from London University. Prior to joining us she was a consultant at Taunton and Somerset NHS Foundation Trust in endocrinology and diabetes. She has held positions with the King's Fund, Royal College of Physicians and the South West Academic Health Science Network.

Appendix B – Further information and contact details

To see our annual reports and accounts

You can look on our website at www.torbayandsouthdevon.nhs.uk or request a copy by writing to the Foundation Trust Office, Hengrave House, Torbay Hospital, Torquay TQ2 7AA. Large print or other formats are available on request.

To obtain additional information available under the Freedom of Information Act, refer to our public website at www.torbayandsouthdevon.nhs.uk For information not available on our public website, contact the Freedom of Information Office at Torbay Hospital on 01803 654868 or email tsdft.foi@nhs.net

To hear more

During the COVID-19 pandemic, we have been holding all corporate meetings, including Board meetings and Council of Governors' meetings virtually. Once the government guidelines for the NHS enable us to meet in person we will revert to holding meetings in public. In the meantime, the public can access recordings of our Board meetings via our website.
For further information contact the Foundation Trust office on 01803 655705 or email foundationtrust.tsdft@nhs.net

To tell us what you think

About this annual report or our forward plans, contact the Communications Office on 01803 217398 or email communications.tsdft@nhs.net

To help us to improve our services

There are opportunities offered through our membership, patient involvement, our League of Friends or through donations. Contact:

- Foundation Trust Office on 01803 655705 or email foundationtrust.tsdft@nhs.net
- League of Friends on 01803 654520 or website www.lof.co.uk
- Torbay and South Devon NHS Charitable Fund (Registered Charity No. 1052232) c/o the Charitable Funds Manager, Regent House, Regent Close, Torquay
  TQ2 7AN

The NHS across South Devon benefits enormously from the work of hundreds of volunteers, giving practical support or fundraising. If you are interested in joining our volunteers, we would welcome your enquiry. Sincere thanks to the hundreds of volunteers who support Torbay Hospital and our community and adult social care services.

- Contact: Voluntary Services Coordinator on 01803 210500

To complain, seek advice or information about aspects of your care our Patient Advice and Liaison Service (PALS) / Feedback and Engagement Team may be able to assist.

- Contact: Telephone 01803 655838 | Free phone 0800 028 2037 | Email tsdft.feedback@nhs.net

To access your health records

An application form can be obtained for records held by Torbay and South Devon NHS Foundation Trust. You may be charged a fee.

- Contact: Data Protection Office on 01803 654868 or email dataprotection.tsdft@nhs.net

To find out about joining our team

As a recruit or returning to work after a break.

- Contact: Recruitment on 01803 654120 or email tsdft.workwithus@nhs.net

For work experience placements

- Contact: email tsdft.workexperience@nhs.net

To find out about South Devon Healthcare Arts

This scheme is supported by staff volunteering their time and by charitable funds generated from the proceeds of sales from art exhibitions staged in The Gallery, Torbay Hospital. The aim is to enhance the health and social care environment.

- Contact: Health and the Arts Torbay and South Devon on 01803 614567

For general health queries

- Contact NHS advice by telephone on 111

Torbay and South Devon NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

These accounts, for the year ended 31 March 2022, have been prepared by Torbay and South Devon NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Liz Davenport**
Job title **Chief Executive**
Date **21 June 2022**

Independent auditor's report to the Council of Governors of Torbay and South Devon NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Torbay and South Devon NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statements of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2022 and of the Group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2021/22 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2021/22, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Group and Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the Group and Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Group and Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraudulent revenue and expenditure recognition. We determined that the principal risks were in respect of the Trust and in relation to:
  - High risk and unusual journals, management estimates including land, buildings and dwellings valuations, private finance initiative liability (PFI) and depreciation and transactions outside the course of business;
  - fraudulent recognition of revenue: we rebutted income received under block contract arrangements, where income received could be verified to agreements with third parties and where income received was immaterial. For variable income streams, we did not consider that we were able to rebut the presumption of fraud.
  - fraudulent expenditure recognition for the purchase of healthcare and social care from NHS and DHSC bodies, drug costs and supplies and services.
- Our audit procedures, which related to the Trust only, involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - selected journal entry testing, with a focus on those journals considered to be unusual, for example: posted by staff with elevated access privileges, or posted by senior officers, or to unusual account combinations.
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations and the PFI liability;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land, buildings and dwellings valuations and the Trust's PFI liability.
- Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;
  - understanding of, and practical experience with, audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Group and Trust operates
  - understanding of the legal and regulatory requirements specific to the Group and Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Signature:

Barrie Morris

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

Date 22nd June 2022

Independent auditor's report to the Council of Governors of Torbay and South Devon NHS Foundation Trust

In our auditor's report issued on 22 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2022, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 22 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Barrie Morris

Barrie Morris, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

Date 8th September 2022

Statement of Comprehensive Income for the year ended 31 March 2022

	Note	Group Year Ended 2021/22 £000	Year Ended 2020/21 £000
Operating income from patient care activities	3	543,680	496,344
Other operating income	4	57,860	63,621
Operating expenses	5	(592,287)	(553,507)
Operating surplus from continuing operations		**9,253**	**6,458**
Finance income	10	19	7
Finance expenses	11	(2,896)	(2,825)
PDC dividends payable		(4,549)	(3,479)
Net finance costs		**(7,426)**	**(6,297)**
Other losses, net	12	(639)	(265)
Corporation tax expense		(22)	(20)
Surplus / (Deficit) for the year from continuing operations		**1,166**	**(124)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	18	2,491	3,233
Total comprehensive income / (expense) for the year		**3,657**	**3,109**
Surplus / (Deficit) for the period attributable to:			
Torbay and South Devon NHS Foundation Trust		1,166	(124)
TOTAL		**1,166**	**(124)**
Total comprehensive income for the year attributable to:			
Torbay and South Devon NHS Foundation Trust		3,657	3,109
TOTAL		**3,657**	**3,109**

Statement of Financial Position as at 31 March 2022

	Notes	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	14	11,864	10,091	11,864	10,091
Property, plant and equipment	15 & 16	239,427	219,481	239,297	219,331
Investments in associates (and joint ventures)	19	0	65	0	65
Receivables	21	1,438	1,975	1,813	2,386
Total non-current assets		**252,729**	**231,612**	**252,974**	**231,873**
Current assets					
Inventories	20	11,395	11,960	10,705	11,309
Receivables	21	27,397	20,551	27,249	20,375
Non-current assets held for sale	22	2,452	687	2,452	687
Cash and cash equivalents	23	39,342	45,445	39,008	45,212
Total current assets		**80,586**	**78,643**	**79,414**	**77,583**
Current liabilities					
Trade and other payables	24	(67,079)	(61,815)	(66,928)	(61,679)
Borrowings	27	(7,476)	(8,235)	(7,476)	(8,235)
Provisions	29	(467)	(383)	(467)	(383)
Other liabilities	26	(10,293)	(7,795)	(10,293)	(7,795)
Total current liabilities		**(85,315)**	**(78,228)**	**(85,164)**	**(78,092)**
Total assets less current liabilities		**248,000**	**232,027**	**247,224**	**231,364**
Non-current liabilities					
Borrowings	27	(48,338)	(55,423)	(48,338)	(55,423)
Provisions	29	(5,955)	(6,131)	(5,955)	(6,131)
Total non-current liabilities		**(54,293)**	**(61,554)**	**(54,293)**	**(61,554)**
Total assets employed		**193,707**	**170,473**	**192,931**	**169,810**
Financed by					
Public dividend capital		150,332	130,755	150,332	130,755
Revaluation reserve		51,538	49,152	51,538	49,152
Income and expenditure reserve		(8,163)	(9,434)	(8,939)	(10,097)
Total taxpayers' equity		**193,707**	**170,473**	**192,931**	**169,810**

The notes on pages 153 to 202 form part of these accounts

Signed .....

Name **Liz Davenport**

Position **Chief Executive**

Date **21 June 2022**

Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**130,755**	**49,152**	**(9,434)**	**170,473**
Deficit for the year	0	0	1,166	**1,166**
Revaluations	0	2,491	0	**2,491**
Transfer to retained earnings on disposal of assets	0	(105)	105	**0**
Public dividend capital received	19,577	0	0	**19,577**
Taxpayers' and others' equity at 31 March 2022	**150,332**	**51,538**	**(8,163)**	**193,707**

Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**67,615**	**46,089**	**(9,480)**	**104,224**
Deficit for the year	0	0	(124)	**(124)**
Revaluations	0	3,233	0	**3,233**
Transfer to retained earnings on disposal of assets	0	(170)	170	**0**
Public dividend capital received	63,140	0	0	**63,140**
Taxpayers' and others' equity at 31 March 2021	**130,755**	**49,152**	**(9,434)**	**170,473**

Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**130,755**	**49,152**	**(10,097)**	**169,810**
Deficit for the year	0	0	1,053	**1,053**
Revaluations	0	2,491	0	**2,491**
Transfer to retained earnings on disposal of assets	0	(105)	105	**0**
Public dividend capital received	19,577	0	0	**19,577**
Taxpayers' and others' equity at 31 March 2022	**150,332**	**51,538**	**(8,939)**	**192,931**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**67,615**	**46,089**	**(10,035)**	**103,669**
Deficit for the year			(232)	**(232)**
Revaluations	0	3,233	0	**3,233**
Transfer to retained earnings on disposal of assets	0	(170)	170	**0**
Public dividend capital received	63,140	0	0	**63,140**
Taxpayers' and others' equity at 31 March 2021	**130,755**	**49,152**	**(10,097)**	**169,810**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

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Statement of Cash Flows

	Note	Group Year ended 2021/22 £000	Group Year Ended 2020/21 £000	Trust Year Ended 2021/22 £000	Trust Year ended 2020/21 £000
Cash flows from operating activities					
Operating surplus / (deficit)		9,253	6,458	9,094	6,304
Non-cash income and expense:					
Depreciation and amortisation	5	17,326	15,898	17,306	15,877
Net impairments	6.1	(863)	3,702	(863)	3,702
Income recognised in respect of capital donations		(299)	(1,324)	(299)	(1,324)
(Increase) / Decrease in receivables and other assets		(5,288)	8,926	(5,316)	8,947
Decrease / (Increase) in inventories		565	(1,683)	604	(1,640)
Increase in payables and other liabilities		4,997	11,493	4,985	12,013
(Decrease) / Increase in provisions		(22)	768	(22)	768
Tax paid		(19)	(33)	0	0
Net cash flows from operating activities		**25,650**	**44,205**	**25,489**	**44,647**
Cash flows from investing activities					
Interest received		19	7	43	33
Purchase of intangible assets		(3,164)	(2,542)	(3,164)	(2,542)
Purchase of Property, Plant and Equipment		(31,849)	(16,515)	(31,849)	(16,515)
Sales of Property, Plant and Equipment		8	92	8	92
Receipt of cash donations to purchase assets		252	86	252	86
Prepayment of PFI capital contributions		0	0	0	0
Net cash flows used in investing activities		**(34,734)**	**(18,872)**	**(34,710)**	**(18,846)**
Cash flows from financing activities					
Public dividend capital received		19,577	63,140	19,577	63,140
Movement on loans from DHSC		(4,805)	(45,086)	(4,805)	(45,086)
Other capital receipts *		0	0	36	36
Capital element of finance lease rental payments		(1,964)	(1,234)	(1,964)	(1,234)
Capital element of PFI obligations		(1,166)	(854)	(1,166)	(854)
Interest paid on loans		(833)	(1,033)	(833)	(1,033)
Interest paid on finance leases liabilities		(415)	(201)	(415)	(201)
Interest paid on PFI obligations		(1,753)	(1,716)	(1,753)	(1,716)
PDC dividend paid		(5,660)	(3,041)	(5,660)	(3,041)
Net cash flows from financing activities		**2,981**	**9,975**	**3,017**	**10,011**
Increase in cash and cash equivalents		**(6,103)**	**35,308**	**(6,204)**	**35,812**
Cash and cash equivalents at 1 April - brought forward		**45,445**	**10,137**	**45,212**	**9,400**
Cash and cash equivalents at 31 March	23	**39,342**	**45,445**	**39,008**	**45,212**

* Other Capital Receipts for the Trust totalling £36,000 (2020/21 £36,000) represents the value of loan principal repayment received from the Trust's wholly owned subsidiary company, SDH Developments Ltd

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

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

Torbay and South Devon NHS Foundation Trust's annual reports and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Note 1.2 Critical judgements and sources of Estimation uncertainty in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision and future periods if the revision affects both current and future periods.

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

Modern equivalent asset valuation of property - key sources of estimation uncertainty

As detailed in accounting policy note 1.8 'Property, plant and equipment - valuation', the Trust has applied a Modern Equivalent Asset approach to valuing its Land and specialised buildings and buildings excluding dwellings. The significant estimate being depreciated replacement value, using modern equivalent methodology - both on an alternative site basis and construction methodology. The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 18 to the financial statements. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Impairments and the estimated lives of assets - key sources of estimation uncertainty

As detailed in accounting policy notes 1.11.2 and 1.12.2, 'Property, Plant and Equipment - Measurement' and 'Intangibles - Measurement', the Trust is required to review property, plant and equipment and intangibles for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors (property, plant and equipment - buildings and buildings excluding dwellings), management make judgements about the condition of assets and review their estimated lives.

Note 1.2 Critical judgements and sources of Estimation uncertainty in applying accounting policies (continued)

Provision for expected credit loss of contract receivables - critical accounting judgement

Management will use their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect debt. There are significant judgements in recognition of revenue from care of patients and clients and in provisioning for disputes with commissioners, clients and customers.

Provisions - critical accounting judgement

Management will use their judgement to decide when to make provisions for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The carrying amounts to the Trust's provisions are detailed in note 29 to the financial statements.

Joint Operations and Income Recognition - critical accounting judgement

The Trust has been commissioned to deliver a Children's and Family Health service to the population of Devon. To deliver this service the Trust has sub-contracted a number of services to neighbouring NHS organisations. The Trust has concluded through a review of contract documentation and by agreement with sub-contractors of the service that a Joint Operation as defined by IFRS11 is not in place, and further the Trust is acting as Principal as opposed to Agent when considering how income and expense should be accounted for. Accordingly in line with IFRS 15, income from the Commissioner is shown gross within the financial statements and those services delivered by Sub-Contractors are included as Purchase of healthcare from NHS and DHSC bodies within Operating Expenditure. The value of the sub-contracted service totalled £14.8m in 2021/22 (2020/21 £11.7m)

Note 1.3 Consolidation

Subsidiary

The Group financial statements consolidate the financial statements of the Trust and its subsidiary undertaking made up to 31 March 2022.
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. In accordance with the NHS Foundation Trust Annual Reporting Manual a separate income statement for the parent (the Trust) has not been prepared.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.
Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material.

The Trust is the Corporate Trustee of Torbay South Devon NHS Charitable Fund (Registered Charity 1052232). Under International Accounting Standards the Charitable Fund is considered to be a subsidiary of the Trust. The financial results of the Charity have not been consolidated into the Trust's Financial Statements. The reason for not consolidating is that it is not thought to be helpful to reader of the Trust accounts and the Trust has elected not to consolidate on the grounds of immateriality.

Joint ventures
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the

Joint Operations
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Note 1.4 Segmental Reporting

During 2021/22 and 2020/21 the Trust did not report its expenditure to the Trust Board using a segmental reporting analysis and therefore representing the data is not possible.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Revenue from Education and training (excluding notional apprenticeship levy income)

The Trust receives income through contracts with Commissioners to deliver Education and Training services to its staff. The Trust recognises the income when performance obligations are satisfied. The income is recognised in line contract values.

Note 1.5 Revenue from contracts with customers (continued)

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means treatment has been given when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Scheme. Both schemes are unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period, The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.10 Discontinued Operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.11 Property, plant and equipment

Note 1.11.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control or form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.11.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Note 1.11.2 Measurement (continued)

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) schemes where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Valuations of the Land and non specialised buildings and specialised buildings are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The latest full revaluation of the Trust's specialised building was undertaken in 2018/19 with a prospective valuation date of 31 March 2019. Full physical valuations take place every 5 years.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expense.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.11.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.11.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2021/22 and 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.11.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.11.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	6	70
Dwellings	36	48
Plant & machinery	2	25
Transport equipment	3	7
Information technology	2	15
Furniture & fittings	2	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term,

Note 1.12 Intangible assets

Note 1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised only where it meets the requirements set out IAS 38.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.12.2 Measurement

Intangible assets are recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner for operational use. They are subsequently valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
The Trust has two classes of Intangible assets. The first are those that are assessed to have finite lives, namely software licences and these are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The other category are assets that are assessed as having indefinite lives. These are not amortised but they are tested by signs of impairment each financial year. The assets that indefinite lives are Licences that the Trust has developed and that in turn enable the Trust to generate an income stream that contributes to the cost of delivering the Trust's health and social care activities

Note 1.12.3 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	13
Licences & trademarks	-	-

Note 1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust has a number of separate stock control systems and consequently cost of inventories is measured by either using on a first in, first out (FIFO) method or the weighted average cost method.

In 2021/22, the Trust continued to receive inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Work in progress comprises goods in intermediate stages of production.

Note 1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.15 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost,

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

Note 1.15 Financial instruments and financial liabilities (continued)

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust undertakes a regular review of its aged debt analysis to ensure that invoices are settled in a prompt manner and to ensure that any debts that show signs of being disputed are escalated appropriately. If as a consequence of an investigation the likelihood of debt recovery is remote, a provision for a potential credit loss is made. A provision for a credit loss for is applied to NHS Recovery Unit debts as advised by NHSI. The Trust also applies a provision for expected credit losses against its Adult Social Care debtors.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected credit losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.16.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.16.2 The trust as lessor continued)

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.17 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022.

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%)

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 30 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for: -

* Donated and Granted assets

* Average daily cash balances / deposits held with the Government Banking Service / National Loan Funds
* Approved expenditure on COVID-19 assets
* Assets under construction for nationally directed schemes.
* Approved expenditure on COVID-19 assets

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.20 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation tax

The Trust is a Health Service Body within the meaning of s986 Corporation Taxes Act 2010. Accordingly it is not liable to corporation tax. The Trust is also exempt from tax on chargeable gains under S271(3) of Chargeable Gains Act 1992.

There is however a power of HM Treasury to submit an order to Parliament, which will dis-apply the corporation tax emption in relation to particular activities of a NHS Foundation Trust (s987 Corporation Taxes Act 2010). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities to be specified in the order which are not related to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the order is approved by Parliament, the trust has no corporation tax liability.

The Trust's subsidiary company profit and losses are subject to Corporation tax, the costs and liability for which are disclosed in the Trust's consolidated financial statements.

Note 1.22 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, where held, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payment

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate is defined by HM Treasury at 0.95% The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	10,660
Additional lease obligations recognised for existing operating leases	(10,544)
Changes to other statement of financial position line items (excluding reserves)	(116)
Net impact on net assets on 1 April 2022	0

	£000
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,320)
Additional finance costs on lease liabilities	(99)
Lease rentals no longer charged to operating expenditure	1,329
Other impact on income / expenditure	0
Estimated impact on surplus / deficit in 2022/23	(90)

	£000
Estimated increase in capital additions for new leases commencing in 2022/23	4,779

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted (continued)

IFRS 16 Leases (continued)

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted. It has not been possible to assess the impact of this standard as it is impracticable to do so.

Note 2 Operating Segments

Note 2.1 Operating Segments 2021/22 and 2020/21 (Group)

The Trust's Chief Operating Decision maker is the Board of Directors.
The Board of Directors functions as a corporate decision-making body. Executive Director and Non-executive Director are full and equal members. Their role as members of the Board of Directors is to consider the key strategic and governance issues facing the Trust in carrying out its statutory and other functions

In line with IFRS 8 'Operating Segments', the Trust uses three key factors in its identification of its reportable operating segments. The factors are that the reportable operating segment: -

* engages in activities from which it earns revenues and incurs expenses

* reports financial results which are regularly reviewed by the Trust's board of directors to make decisions about allocation of resources to the segment and assess its performance

* has discrete financial information.

Due to the impact of COVID-19 has had on the operation of health and social care activities during 2021/22 and 2020/21 the Trust Board received financial information on its operation as a whole. Budgeting and investment decisions are also considered at a whole 'system' level (i.e. the impact is considered at both Trust wide and Commissioner level). Investment decisions are not purely financially driven and the complexity of the information provided to the Trust Board to support the decision making will vary depending upon the nature and scale of the investments being proposed. Accordingly the information received by the Trust Board during 2020/21 is in accordance with these financial accounts.

Note 3 Operating income from patient care activities, by nature. (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income *	315,030	274,929
High cost drugs income from commissioners	22,935	21,074
Other NHS clinical income *	8,909	4,876
Community services		
Block contract / system envelope income *	106,311	106,311
Income from other sources (e.g. local authorities)	73,476	74,151
All trusts		
Private patient income	633	610
Elective recovery fund	3,744	-
Additional pension contribution central funding **	12,199	11,522
Other clinical income**	443	2,871
Total income from patient care activities	**543,680**	**496,344**

*At the start of 2020/21, a part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments. In the second half of 2020/21, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. The financial framework used during 2021/22 was similar to that used in the second half of 2020/21.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administrative charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts

Note 3.1 Income from patient care activities, by source (Group)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	57,149	56,644
Clinical commissioning groups	410,416	361,818
NHS Foundation Trusts	0	35
NHS Trusts	2,112	2,368
Local authorities	60,234	62,354
Non-NHS: private patients	633	583
Non-NHS: overseas patients (chargeable to patient)	45	27
NHS injury scheme *	346	315
Non NHS: other **	12,745	12,200
Total income from activities	**543,680**	**496,344**
Of which:		
Related to continuing operations	543,680	496,344
Related to discontinued operations	0	0

* NHS Injury Scheme Income is subject to a provision for doubtful debts of 23.76% (2020/21 22.43%) to reflect expected rates of collection

** Non NHS Other Income is comprised mostly of Adult Social Care Client Contributions; Adult Social Care costs being means tested.

Note 3.2 Overseas visitors (relating to patients charged directly by the provider) (Group)

	2021/22 £000	2020/21 £000
Income recognised this year	45	27
Cash payments received in-year	27	20
Amounts added to provision for impairment of receivables	0	0
Amounts written off in-year	5	38

Note 4 Other operating income (Group)

	2021/22 Contract income £000	2021/22 Non-contract income £000	2021/22 Total £000	2020/21 Contract income £000	2020/21 Non-contract income £000	2020/21 Total £000
Research and development (contract)	3,024	-	3,024	1,246	-	1,246
Education and training (excluding notional apprenticeship levy income)	11,705	-	11,705	9,923	-	9,923
Non-patient care services to other bodies	8,358	-	8,358	4,614	-	4,614
Reimbursement and top up funding	3,763	-	3,763	15,774	-	15,774
Other income (recognised in accordance with IFRS15) *	27,446	-	27,446	25,413	-	25,413
Education and training - notional income from apprenticeship fund	-	989	989	-	655	655
Donations of physical assets (non cash)	-	0	0	-	0	0
Donated equipment from DHSC for COVID response (non-cash)	-	47	47	-	1,238	1,238
Cash donations for the purchase of capital assets - received from NHS charities	-	252	252	-	86	86
Charitable and other contributions to expenditure - received from other bodies	-	399	399	-	0	0
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold	-	253	253	-	117	117
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	-	851	851	-	3,800	3,800
Rental revenue from operating leases	-	773	773	-	755	755
Total other operating income	**54,296**	**3,564**	**57,860**	**56,970**	**6,651**	**63,621**
Of which:						
Related to continuing operations			57,860			63,621
Related to discontinued operations			0			0

* Other income (recognised in accordance with IFRS 15) includes £21.6m of sales (2020/21 £20.2m) from the Trust's Pharmacy Manufacturing Unit. Other income (recognised in accordance with IFRS 15) also includes £1.4m (2020/21 £1.6m) from hosting the Audit South West - Internal Audit Counter Fraud and Consultancy Services

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period (Group)

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included within contract liabilities at the end of the previous period	7,417	6,229
Revenue recognised from performance obligations satisfied (or partially satisfied in previous periods)	0	0

Note 4.2 Transaction price allocated to remaining performance obligations (Group)

	31 March 2022 £000	31st March 2021 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	10,293	7,795
after one year, not later than five years	0	0
after five years	0	0
	10,293	**7,795**

Note 4.3 Income from activities arising from commissioner requested services (Group)

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	526,661	481,341
Income from services not designated as commissioner requested services	17,019	15,003
Total	**543,680**	**496,344**

Note 4.4 Profits and losses on disposal of property, plant and equipment (Group)

During 2021/22 the Trust disposed of a number of Property, Plant and Equipment items and Intangible assets, the net loss of which was £639,000 (2020/21 net loss of £265,000). £551,000 of the net loss of £639,000 related to items of medical equipment, donated to the Trust by the NHS during 2020/21 to assist the pandemic response, which were not required and were returned during 2021/22.

Note 5 Operating expenses (Group)

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	17,377	13,926
Purchase of healthcare from non-NHS and non-DHSC bodies	47,859	51,755
Purchase of social care	72,468	64,343
Staff and executive directors costs	293,570	274,552
Remuneration of non-executive directors	174	172
Supplies and services – clinical (excluding drugs costs)	36,030	31,041
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	1,315	3,185
Supplies and services - general	5,269	4,901
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	253	117
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	37,109	31,359
Inventories written down	121	95
Inventories written down (consumables donated from DHSC group bodies for COVID response)	0	115
Consultancy	362	29
Establishment	3,181	2,897
Premises	20,410	18,260
Transport (including patient travel)	3,026	2,409
Depreciation on property, plant and equipment	15,035	12,858
Amortisation on intangible assets	2,291	3,040
Net impairments	(863)	3,702
Movement in credit loss allowance: contract receivables/assets	777	597
Increase/(decrease) in other provisions	166	790
Change in provisions discount rates	162	195
Audit fees payable to the external auditor:		
audit services- statutory audit *	136	123
other auditor remuneration (external auditor only)	0	0
Internal audit costs**	320	318
Clinical negligence	8,358	7,654
Legal fees	465	349
Insurance	65	128
Research and development - staff costs	1,812	1,583
Research and development - non-staff	83	55
Education and training - staff costs	10,159	9,290
Education and training - non-staff	1,809	1,680
Education and training - notional expenditure funded from apprenticeship fund	989	655
Rentals under operating leases	1,367	1,309
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	1,254	1,404
Grossing up consortium arrangements	1,176	1,459
Other	8,202	7,162
Total	**592,287**	**553,507**
Of which:		
Related to continuing operations	592,287	553,507
Related to discontinued operations	0	0

*** External Audit Fees.** The costs reported above includes a fee of £119k (2020/21 £106k) chargeable by the auditor, Grant Thornton LLP, responsible for the audit of the Trust and Group reported position. This fee is inclusive of VAT as this is non-recoverable by the Trust. In addition to this fee, £17k (2020/21 £17k) has been charged for the audit of the Trust's subsidiary company. In 2020/21 the Subsidiary Company audit was undertaken by Grant Thornton LLP. In 2021/22 the audit of the Subsidiary Company will be undertaken by new auditors, the appointment for which is being finalised.

**** Internal Audit costs.** The costs reported above represent the pay costs of the Internal Audit and Counter Fraud services the Trust has received the benefit of during the financial years. The Trust is part of a Peninsular wide Internal Audit and Counter Fraud consortium, where resources are shared with other and recharged to other NHS organisations. For accounting purposes, Torbay and South Devon NHS Foundation Trust operates as the lead consortium member. The Trust employs a proportion of the Audit and Counter Fraud consortiums staff. The value of charges made to the Trust by other organisations is shown as a 'Grossing up consortium arrangements' cost in operating expenditure and the value of charges made by the Trust as Lead Consortium member is recorded on 'Other income' within Other Operating Income.

Note 5.1 Other auditor remuneration (Group)

	2021/22 £000	2020/21 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	0	0
Total	**0**	**0**

No non-statutory fees were paid to the Trust's auditors during 2021/22 (2020/21 £0k). The Trust's external auditor was during 2020/21 also engaged to provide statutory audit services for Torbay and South Devon NHS Charitable Fund, for which the Trust is the Corporate Trustee (see also note 37.3). In 2020/21, this fee was £11.8k excl VAT. The Trust's external auditor resigned from this appointment in May 2022. A new auditor for Torbay and South Devon NHS Charitable Fund has yet to be appointed.

Note 5.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2020/21: £2m).

Note 6 Net impairments (Group)

Note 6.1 Net Impairments total (Group)

	Note	2021/22 £000	2020/21 £000
Net impairments charged / (credited) to operating surplus / (deficit) surplus resulting from:			
Loss or damage from normal operations	6.2	276	2,308
Abandonment of assets in the course of construction	6.3	0	311
Changes in market price	6.4	(1,139)	1,083
Total net impairments credited to operating surplus		**(863)**	**3,702**

Note 6.2 Loss or damage from normal operations (Group)

Impairments from 'Loss or damage from normal operations' totalled £276k, during 2021/22 (2020/21 £2,308k) . The impairment processed in 2021/22 related to one asset (2020/21, ten assets). The one asset impaired during 2021/22 was a component of 'Building excluding dwellings' (2020/21, zero assets, £0k). During 2020/21 items of Plant & Machinery, total of eight assets, £245k; one Intangible software asset totalling £1,957k and one Intangible licence totalling £106k were impaired. The asset impaired during 2021/22 related to a construction project that necessitated the removal of an existing modular structure. The assets impaired during 2020/21 followed a review undertaken by management that concluded that these assets were no longer providing an economic return to the Trust's operations and had little prospect of producing a future return and therefore in line with IAS 36 - Impairment of Assets, the assets carrying value have been written down.

Note 6.3 Abandonment of assets in the course of construction (Group)

No abandonment of assets in the course of construction took place during 2021/22. Abandonment of assets in the course of construction totalling £311k during 2020/21 related to four items of Plant & Machinery totalling £266k and one Intangible asset totalling £45k. All were associated with the Trust's Pharmaceutical Manufacturing Activity. Management concluded that these assets were unlikely to drive an economic return for the Trust and therefore the net book value of these items were written down to £NIL as at 31st March 2021

Note 6.4 Changes to market price (Group)

	2021/22 £000	2020/21 £000
Net impairments (credited) / charged to operating surplus resulting from:		
Revaluation of Trust's Buildings and Dwelling assets	(867)	1,403
Revaluation of Land	(272)	(320)
	(1,139)	**1,083**

The Trust commissioned the District Valuation Office in both 2021/22 and 2020/21 to provide an updated valuation of the Trust's properties as at 31st March 2022 and 31st March 2021 respectively. The valuation exercises consisted of desktop reviews and also application of BCIS and local indexation factors. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but available for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value. The review increased the value of PPE Land, Buildings and Buildings excluding Dwellings by a net £3,630k (2020/21, £2,150k). Of the increase in value, £2,491k (2020/21, £3,233k) has been credited to the Trust's revaluation reserve and a net £1,139k has been credited (2019/20 charged, £1,083k) to Operating Expenditure as an Impairment credit.

Note 7 Employee benefits (Group)

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	232,433	220,906
Social security costs	21,588	19,946
Apprenticeship levy	1,125	1,047
Employer's contributions to NHS Pension scheme	27,827	26,260
Employer's contributions paid by NHSE on provider's behalf to NHS Pension scheme	12,199	11,522
Pension cost - other	50	58
Temporary staff (including agency)	13,247	7,630
Total gross staff costs	**308,469**	**287,369**
Costs capitalised as part of assets	2,608	1,626

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administrative charge) from 1 April 2019. From 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts

Note 7.1 Retirements due to ill-health (Group)

During 2021/22 there were 2 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £85k (£182k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension scheme.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 9 Operating leases (Group)

Note 9.1 Torbay and South Devon NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Torbay and South Devon NHS Foundation Trust is the lessor.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	773	755
Total	**773**	**755**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	650	635
- later than one year and not later than five years;	2,600	2,538
- later than five years.	1,950	2,538
Total	**5,200**	**5,711**

The Trust had a lease agreement with Devon Partnership Trust (DPT) which expired 31st March 2020. During 2020/21, this arrangement was extended and the Trust signed a new lease agreement with DPT for a period of 10 years from 1st April 2020. In 2021/22 this income totalled £773,000 (2020/21 £755,000). The lease income received in year and future minimum lease receipts due all relate to lease of buildings.

Note 9.2 Torbay and South Devon NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Torbay and South Devon NHS Foundation Trust is the lessee.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	1,268	1,179
Contingent rents	99	130
Total	**1,367**	**1,309**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	1,264	559
- later than one year and not later than five years;	4,191	798
- later than five years.	5,068	131
Total	**10,523**	**1,488**
Future minimum sublease payments to be received *	10,523	1,488

* - Included in these commitments is £3.6m (2020/21 £0.1m) for Regent House, a building in Regent Close, Torquay, where an extension to the existing lease has been agreed with the landlord for a period of 10 years (rent review due in 5 years). The Trust has also entered into a new 25 year lease for part of Sherborne House, a building in Newton Abbot. The total sum of commitments for this facility totals £3.8m (2020/21 £0.0m) with rent being inflated by RPI each year. The Trust also acts as an agent for members of staff leasing vehicles through a salary sacrifice scheme and the lease commitments of £1.0m (2020/21 £0.8m) are not included in the figures disclosed above.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2021/22 £000	2020/21 £000
Interest on bank accounts	19	7
Total	**19**	**7**

Note 11 Finance expenses (Group)

Finance expenses represents interest and other charges involved in the borrowing of money or asset financing

	2021/22 £000	2020/21 £000
Interest expense:		
Loans from the Department of Health and Social Care	814	944
Other loans		
Overdrafts		
Finance leases	399	211
Interest on late payment of commercial debt		
Main finance costs on PFI schemes obligations	1,091	1,161
Contingent finance costs on PFI schemes obligations	662	555
Total interest expense	**2,966**	**2,871**
Unwinding of discount on provisions	(70)	(46)
Other finance costs		
Total finance costs	**2,896**	**2,825**

Note 11.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22 £000	2020/21 £000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 12 Other losses, net (Group)

	2021/22 £000	2020/21 £000
Gains on disposal of assets	4	17
Losses on disposal of assets	(643)	(282)
Total losses, net on disposal of assets	**(639)**	**(265)**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's suplus for the period was £1,053k (2020/21 deficit of £232k). The trust's total comprehensive income for the period was £3,544k (2020/21: £3,001k).

Note 14 Intangible assets - Group and Trust

Note 14.1 Intangible assets - 2021/22

Group and Trust	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**16,158**	**1,037**	**0**	**3,598**	**20,793**
Additions	539	5	0	3,933	**4,477**
Impairments	0	0	0	0	**0**
Reclassifications	240	664	0	(1,857)	**(953)**
Disposals / derecognition	(1,325)	0	0	0	**(1,325)**
Valuation / gross cost at 31 March 2022	**15,612**	**1,706**	**0**	**5,674**	**22,992**
Accumulated Amortisation at 1 April 2021 - brought forward	**10,702**	**0**	**0**	**0**	**10,702**
Provided during the year	2,291	0	0	0	**2,291**
Reclassifications	(575)	0	0	0	**(575)**
Disposals / derecognition	(1,290)	0	0	0	**(1,290)**
Accumulated Amortisation at 31 March 2022	**11,128**	**0**	**0**	**0**	**11,128**
Net book value at 31 March 2022	**4,484**	**1,706**	**0**	**5,674**	**11,864**
Net book value at 31 March 2021	**5,456**	**1,037**	**0**	**3,598**	**10,091**

Note 14.2 Intangible assets - 2020/21

Group and Trust	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**18,233**	**1,131**	**0**	**2,346**	**21,710**
Additions	871	9	0	2,298	**3,178**
Impairments	(1,957)	(106)	0	(45)	**(2,108)**
Reclassifications	981	3	0	(1,001)	**(17)**
Disposals / derecognition	(1,970)	0	0	0	**(1,970)**
Valuation / gross cost at 31 March 2021	**16,158**	**1,037**	**0**	**3,598**	**20,793**
Accumulated Amortisation at 1 April 2020 - as previously stated	**9,588**	**0**	**0**	**0**	**9,588**
Provided during the year	3,040	0	0	0	**3,040**
Disposals / derecognition	(1,926)	0	0	0	**(1,926)**
Accumulated Amortisation at 31 March 2021	**10,702**	**0**	**0**	**0**	**10,702**
Net book value at 31 March 2021	**5,456**	**1,037**	**0**	**3,598**	**10,091**
Net book value at 31 March 2020	**8,645**	**1,131**	**0**	**2,346**	**12,122**

Note 15 Property, plant and equipment - Group

Note 15.1 Property, plant and equipment - 2021/22

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**9,273**	**153,927**	**4,204**	**23,523**	**59,078**	**1,377**	**21,455**	**4,852**	**277,689**
Additions	0	1,268	12	31,327	863	29	17	45	**33,561**
Impairments	0	(1,424)	0	0	0	0	0	0	**(1,424)**
Reversals of impairments	272	2,015	0	0	0	0	0	0	**2,287**
Revaluations	115	(4,557)	(210)	0	0	0	0	0	**(4,652)**
Reclassifications	0	6,255	300	(15,631)	7,080	77	2,808	64	**953**
Transfers to/ from assets held for sale	(1,700)	0	0	0	0	0	0	0	**(1,700)**
Disposals / derecognition	0	0	0	0	(3,027)	(109)	(927)	(4,537)	**(8,600)**
Valuation/gross cost at 31 March 2022	**7,960**	**157,484**	**4,306**	**39,219**	**63,994**	**1,374**	**23,353**	**424**	**298,114**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**35**	**0**	**0**	**37,474**	**974**	**15,058**	**4,667**	**58,208**
Provided during the year	0	6,923	246	0	5,424	133	2,261	48	**15,035**
Revaluations	0	(6,897)	(246)	0	0	0	0	0	**(7,143)**
Reclassifications	0	0	0	0	575	0	0	0	**575**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,439)	(109)	(903)	(4,537)	**(7,988)**
Accumulated depreciation at 31 March 2022	**0**	**61**	**0**	**0**	**41,034**	**998**	**16,416**	**178**	**58,687**
Net book value at 31 March 2022	**7,960**	**157,423**	**4,306**	**39,219**	**22,960**	**376**	**6,937**	**246**	**239,427**
Net book value at 31 March 2021	**9,273**	**153,892**	**4,204**	**23,523**	**21,604**	**403**	**6,397**	**185**	**219,481**

Note 15 Property, plant and equipment - Group

Note 15.2 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**7,708**	**149,574**	**4,255**	**10,500**	**60,868**	**1,416**	**21,920**	**4,804**	**261,045**
Additions	0	7,730	50	20,245	3,709	6	1,468	23	**33,231**
Impairments	0	(2,328)	0	(266)	(245)	0	0	0	**(2,839)**
Reversals of impairments	320	925	0	0	0	0	0	0	**1,245**
Revaluations	1,245	(4,394)	(104)	0	0	0	0	0	**(3,253)**
Reclassifications	0	2,420	3	(6,956)	1,468	0	3,052	30	**17**
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(6,722)	(45)	(4,985)	(5)	**(11,757)**
Valuation/gross cost at 31 March 2021	**9,273**	**153,927**	**4,204**	**23,523**	**59,078**	**1,377**	**21,455**	**4,852**	**277,689**
Accumulated depreciation at 1 April 2020 - as previously stated	**0**	**46**	**0**	**0**	**39,570**	**883**	**18,158**	**4,623**	**63,280**
Provided during the year	0	6,256	219	0	4,349	136	1,849	49	**12,858**
Revaluations	0	(6,267)	(219)	0	0	0	0	0	**(6,486)**
Disposals / derecognition	0	0	0	0	(6,445)	(45)	(4,949)	(5)	**(11,444)**
Accumulated depreciation at 31 March 2021	**0**	**35**	**0**	**0**	**37,474**	**974**	**15,058**	**4,667**	**58,208**
Net book value at 31 March 2021	**9,273**	**153,892**	**4,204**	**23,523**	**21,604**	**403**	**6,397**	**185**	**219,481**
Net book value at 31 March 2020	**7,708**	**149,528**	**4,255**	**10,500**	**21,298**	**533**	**3,762**	**181**	**197,765**

Note 15.3 Property, plant and equipment financing - 2021/22

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	7,960	133,451	4,306	38,643	16,046	79	3,014	230	**203,729**
Finance leased	0	560	0	576	4,625	270	3,889	0	**9,920**
On-SoFP PFI contracts and other service concession arrangements	0	17,598	0	0	0	0	0	0	**17,598**
Owned - donated / granted	0	5,814	0	0	1,699	27	34	16	**7,590**
Owned - equipment donated from DHSC and NHSE for COVID response	0	0	0	0	590	0	0	0	**590**
NBV total at 31 March 2022	**7,960**	**157,423**	**4,306**	**39,219**	**22,960**	**376**	**6,937**	**246**	**239,427**

Note 15.4 Property, plant and equipment financing - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	9,273	131,047	4,204	17,926	14,996	35	3,635	165	**181,281**
Finance leased	0	0	0	5,597	3,267	368	2,706	0	**11,938**
On-SoFP PFI contracts and other service concession arrangements	0	17,109	0	0	0	0	0	0	**17,109**
Owned - donated / granted	0	5,736	0	0	3,341	0	56	20	**9,153**
NBV total at 31 March 2021	**9,273**	**153,892**	**4,204**	**23,523**	**21,604**	**403**	**6,397**	**185**	**219,481**

Note 16 Property, plant and equipment - Trust

Note 16.1 Property, plant and equipment - 2021/22

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**9,273**	**153,927**	**4,204**	**23,523**	**58,870**	**1,377**	**21,455**	**4,852**	**277,481**
Additions	0	1,268	12	31,327	863	29	17	45	**33,561**
Impairments	0	(1,424)	0	0	0	0	0	0	**(1,424)**
Reversals of impairments	272	2,015	0	0	0	0	0	0	**2,287**
Revaluations	115	(4,557)	(210)	0	0	0	0	0	**(4,652)**
Reclassifications	0	6,255	300	(15,631)	7,080	77	2,808	64	**953**
Transfers to/ from assets held for sale	(1,700)	0	0	0	0	0	0	0	**(1,700)**
Disposals / derecognition	0	0	0	0	(3,027)	(109)	(927)	(4,537)	**(8,600)**
Valuation/gross cost at 31 March 2022	**7,960**	**157,484**	**4,306**	**39,219**	**63,786**	**1,374**	**23,353**	**424**	**297,906**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**35**	**0**	**0**	**37,416**	**974**	**15,058**	**4,667**	**58,150**
Provided during the year	0	6,923	246	0	5,404	133	2,261	48	**15,015**
Revaluations	0	(6,897)	(246)	0	0	0	0	0	**(7,143)**
Reclassifications	0	0	0	0	575	0	0	0	**575**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,439)	(109)	(903)	(4,537)	**(7,988)**
Accumulated depreciation at 31 March 2022	**0**	**61**	**0**	**0**	**40,956**	**998**	**16,416**	**178**	**58,609**
Net book value at 31 March 2022	**7,960**	**157,423**	**4,306**	**39,219**	**22,830**	**376**	**6,937**	**246**	**239,297**
Net book value at 31 March 2021	**9,273**	**153,892**	**4,204**	**23,523**	**21,454**	**403**	**6,397**	**185**	**219,331**

Note 16 Property, plant and equipment - Trust

Note 16.2 Property, plant and equipment - 2020/21

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	7,708	149,574	4,255	10,500	60,660	1,416	21,920	4,804	260,837
Additions	0	7,730	50	20,245	3,709	6	1,468	23	33,231
Impairments	0	(2,328)	0	(266)	(245)	0	0	0	(2,839)
Reversals of impairments	320	925	0	0	0	0	0	0	1,245
Revaluations	1,245	(4,394)	(104)	0	0	0	0	0	(3,253)
Reclassifications	0	2,420	3	(6,956)	1,468	0	3,052	30	17
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(6,722)	(45)	(4,985)	(5)	(11,757)
Valuation/gross cost at 31 March 2021	9,273	153,927	4,204	23,523	58,870	1,377	21,455	4,852	277,481
Accumulated depreciation at 1 April 2020 - as previously stated	0	46	0	0	39,533	883	18,158	4,623	63,243
Provided during the year	0	6,256	219	0	4,328	136	1,849	49	12,837
Revaluations	0	(6,267)	(219)	0	0	0	0	0	(6,486)
Disposals / derecognition	0	0	0	0	(6,445)	(45)	(4,949)	(5)	(11,444)
Accumulated depreciation at 31 March 2021	0	35	0	0	37,416	974	15,058	4,667	58,150
Net book value at 31 March 2021	9,273	153,892	4,204	23,523	21,454	403	6,397	185	219,331
Net book value at 31 March 2020	7,708	149,528	4,255	10,500	21,127	533	3,762	181	197,594

Note 16.3 Property, plant and equipment financing - 2021/22

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	7,960	133,451	4,306	38,643	15,916	79	3,014	230	**203,599**
Finance leased	0	560	0	576	4,625	270	3,889	0	**9,920**
On-SoFP PFI contracts and other service concession arrangements	0	17,598	0	0	0	0	0	0	**17,598**
Owned - donated / granted	0	5,814	0	0	1,699	27	34	16	**7,590**
Owned - equipment donated from DHSC and NHSE for COVID response	0	0	0	0	590	0	0	0	**590**
NBV total at 31 March 2022	**7,960**	**157,423**	**4,306**	**39,219**	**22,830**	**376**	**6,937**	**246**	**239,297**

Note 16.4 Property, plant and equipment financing - 2020/21

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	9,273	131,047	4,204	17,926	14,846	35	3,635	165	**181,131**
Finance leased	0	0	0	5,597	3,267	368	2,706	0	**11,938**
On-SoFP PFI contracts and other service concession arrangements	0	17,109	0	0	0	0	0	0	**17,109**
Owned - donated / granted	0	5,736	0	0	2,141	0	56	20	**7,953**
Owned - equipment donated from DHSC and NHSE for COVID response	0	0	0	0	1,200	0	0	0	**1,200**
NBV total at 31 March 2021	**9,273**	**153,892**	**4,204**	**23,523**	**21,454**	**403**	**6,397**	**185**	**219,331**

Note 17 Donations of property, plant and equipment and intangibles (Group)

The Trust has benefitted from the receipt of Charitable Donations of Property, Plant and Equipment during 2021/22 £252,000 (2020/21 total of £86,000). No restrictions have been placed on the use of these Charitable Donations by the donors.

The categorisation of the Charitable additions was as follows: - Buildings excluding dwellings £51k (2020/21 £0k), Plant & Machinery £172k (2020/21 £85k), Transport equipment £29k (2020/21: £0) and Information Technology £0 (2020/21 £1k).

During 2020/21 the Trust also benefited from the receipt of equipment donated by the Department of Health and Social Security (DHSC) for the NHS's response to the Covid-19 Pandemic. The total capital value of equipment received by the Trust totalled £47k (2020/21: £1,238k). During the year, items totalling £551k were deemed to be surplus to requirements and were returned to DHSC.

Note 18 Revaluations of property, plant and equipment and intangibles (Group)

As described in note 6 to the Accounts 'Impairment of Assets', the Trust commissioned the District Valuation Office to undertake a full desk top revaluation during the course of 2020/21, namely: -

Provision of a **v**aluation for land and buildings that were surplus to Trust needs and were available for sale; provision of a valuation of land and building assets not currently available for sale and a valuation of land, and provision for buildings and dwellings in use as at 31st March 2022. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but available for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value.

The overall net impact of the above revaluations has been to increase the value of the Trust's Property, Plant and Equipment items by £3,630k (2020/21 £2,150k). Of this net increase, a net £1,139k has been credited against operating expenditure as a 'Reversal of impairment' (2020/21: net 'Impairment' charge of £1,083k) and the balance of £2,491k (2020/21 £3,233k) has been credited to the revaluation reserve.

Note 19 Investments in Subsidiary, Associates and joint ventures

The Trust's principal subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out in these financial statements.

The reporting data of the financial statements for the subsidiary is the same as for these group financial statements - 31 March 2022.

Investment in Subsidiary - SDH Developments Ltd

The Trust's wholly owned subsidiary company is registered in the UK, company no. 08385611 with a share capital comprising one share £1 owned by the Trust. The company commenced trading on 1st July 2013 as an Outpatients Dispensing service in Torbay Hospital and a significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The subsidiary company reported a £113k post tax profit in the year ending 31st March 2022 (2020/21 £108k). Its gross and net assets at 31st March 2022 were £2,289k (2020/21 £2,186k) and £776k (2020/21 £663k) respectively. The management of the subsidiary company produce their own tax computations, supported with professional advice which due to ethical standards the auditors can no longer produce. There has been no significant change in the trading risks during the course of this year.

Investments in associates and joint ventures outside of the government accounting boundary

	Group and Trust	
	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**65**	**65**
Transfer to assets held for sale	(65)	0
Carrying value at 31 March	**0**	**65**

During 2016/17 the Trust invested £35,000 in a Limited Liability Partnership trading as 'Health and Care Innovations LLP'. A further £30,000 investment was made by the Trust during 2019/20. The Trust holds a 50% equity stake in the business. The principal purpose of the LLP was to develop, produce and market healthcare related educational videos. During 2021/22, the Trust agreed to sell its stake in the business, with this sale due to be completed in 2022/23, and the investment has therefore been recognised as an asset held for sale. On the grounds of materiality the Trust has not consolidated the results of the LLP into these financial statements.

During 2018/19 the Trust together with a Partner formed a LLP named 'SDH Innovations Partnership LLP'. The Trust holds a 50% equity stake in the business, namely share capital of £1 nominal value. The principal purpose of the LLP is a vehicle to support the development of new healthcare facilities with a Strategic Estates Partner. On the grounds of materiality the Trust has not consolidated the results of the LLP into these financial statements.

Note 20 Inventories

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Drugs	2,534	2,319	1,844	1,668
Consumables	2,957	3,271	2,957	3,271
Energy	24	29	24	29
Other *	5,880	6,341	5,880	6,341
Total inventories	**11,395**	**11,960**	**10,705**	**11,309**
of which:				
Held at fair value less costs to sell	0	0	0	0

* Other Inventories includes £5,547k of stock manufactured by the Trust's Pharmacy Manufacturing Unit in readiness for sale as well as associated raw materials (2020/21 £6,047k).

Inventories recognised in expenses for the year were £52,742k (2020/21: £45,204k). Of the inventories recognised in expense £1,315k related to Consumables donated from DHSC group bodies (2020/21 £3,185k). Write-down of inventories recognised as expenses for the year totalled £121k (2020/21: £210k). Of the Write down of inventories recognised as expenses for the year none related to Consumables from DHSC group bodies (2020/21 £115k).

Note 21 Receivables

Note 21.1 Receivables total

		Group		Trust	
	Note	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Current					
Contract receivables (IFRS15) : invoiced *		14,503	11,105	14,503	11,105
Contract receivables (IFRS 15) : not yet invoiced / non-invoiced **		7,391	5,576	7,421	5,606
Allowance for impaired contract receivables / assets		(1,674)	(1,019)	(1,674)	(1,019)
Prepayments (non-PFI)		4,162	3,799	4,162	3,799
PDC dividend receivable		1,021	0	1,021	0
VAT receivable		1,840	1,040	1,662	834
Other receivables		154	50	154	50
Total current trade and other receivables		**27,397**	**20,551**	**27,249**	**20,375**
Non-current					
Contract receivables (IFRS 15) : not yet invoiced / non-invoiced * & **		437	558	437	558
Finance lease receivables	28.1	501	502	501	502
Clinician pension tax provision reimbursement funding from NHS England ***		500	915	500	915
Other receivables		0	0	375	411
Total non-current trade and other receivables		**1,438**	**1,975**	**1,813**	**2,386**
Of which receivables from NHS and DHSC group bodies:					
Current		9,543	4,874	9,543	4,874
Non-current		743	1,158	743	1,158

*** Contract receivables (IFRS15) : invoiced,** includes Adult Social Care Debt of £6,297k (2020/21 £5,228k).

**** Contract receivables (IFRS15) : not yet invoiced / non invoiced.** includes NHS Injury Unit receivables £1,087k (2020/21 £1,208k)

*** & **** The value of Contract receivables at 31st March 2022 in comparison with the position at 31st March 2021 has increased, primarily due to a return to more normal contracting arrangements, following the unusual arrangements in place during 2020/21. More details of contracting arrangements are disclosed in the Accounting Policy Note 1.5 to these financial statements - 'Revenue from Contracts with Customers'

***** Clinician pension tax provision reimbursement funding from NHS England,** relates to monies due to offset the potential liability the Trust is exposed to in underwriting the tax liabilities Clinicians are facing relating to increases in their Pensions above and above their Annual Allowances in respect of 2020/21. Please refer to 'Provisions' - note 29 to these financial statements for further analysis.

Note 21 Trade receivables and other receivables

Note 21.2 Allowance for credit losses - 2021/22

	Group and Trust		
	Contract receivables and contract assets £000	All other receivables £000	Total £000
Allowances as at 1 April 2021	**1,019**	**0**	1,019
New allowances arising	790	0	790
Reversals of allowances	(13)	0	(13)
Utilisation of allowances (write offs)	(122)	0	(122)
Allowance at 31 March 2022	**1,674**	**0**	**1,674**
Loss recognised in expenditure	**777**	**0**	**777**

Note 21.3 Allowance for credit losses - 2020/21

	Group and Trust		
	Contract receivables and contract assets £000	All other receivables £000	Total £000
Allowances as at 1 April 2020	**3,041**	**0**	3,041
New allowances arising	664	0	664
Reversals of allowances	(67)	0	(67)
Amounts utilised	(2,619)	0	(2,619)
Allowance at 31 March 2021	**1,019**	**0**	**1,019**
Loss recognised in expenditure	**597**	**0**	**597**

Note 21.4 Credit quality of financial assets (continued)

The Trust undertakes a regular review of its aged debt analysis to ensure that invoices are settled in a prompt manner and to ensure that any debts that show signs of being disputed are escalated appropriately. If as a consequence of an investigation the likelihood of debt recovery is remote, an allowance for credit loss is made. As described in Note 3.2 Operating Income, a general allowance for expected credit losses is applied to NHS Recovery Unit debts as advised by DHSC. The Trust also applies a general provision for expected credit losses against its Adult Social Care client contribution debtors. This general provision is based upon a forward looking view supplemented with long standing historical experience of recovering these type of debts. The general provision has been recently reviewed due to the impact that COVID-19 has had on Adult Social Care debt levels.

The Trust has reviewed the value of its non impaired debts associated with non Adult Social Care Client contributions beyond their settlement dates and has concluded that these debts are likely to be recoverable.

Note 22 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2021/22	2020/21
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**687**	**687**
Assets classified as available for sale in the year	1,765	0
Assets sold in year	0	0
Impairment of assets held for sale	0	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	**2,452**	**687**

During the course of 2021/22, neither of the two assets being marketed for sale as at 31st March 2021 have been disposed of. One is a vacant property and the other is a surplus piece of land. During 2021/22 market conditions for the sale of these type of assets that require planning permission from the purchasers perspective have been difficult, due to the impact of Covid 19. The Trust anticipates that the disposals will take place during the next twelve months. In addition, two new assets have been classified as for sale. The Trust has agreed to sell its stake in Health and Care Innovations LLP, which has a carrying value of £65k. The sale is expected to complete during 2022/23 (see also note 19). The Trust is also currently marketing for sale the former Dartmouth & Kingswear Community Hospital with a carrying value of £1,700k.

Note 23 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
At 1 April	**45,445**	**10,137**	**45,212**	**45,212**
Net change in year	(6,103)	35,308	(6,204)	0
At 31 March	**39,342**	**45,445**	**39,008**	**45,212**
Broken down into:				
Cash at commercial banks and in hand	356	255	22	22
Cash with the Government Banking Service	38,986	45,190	38,986	45,190
Total cash and cash equivalents as in SoFP and SoCF	**39,342**	**45,445**	**39,008**	**45,212**

During 2020/21 a Working Capital Loan Facility totalling £11.0m was repaid in full by the Trust, the repayment of which was funded by the issue of £11.0m of Public Dividend Capital from the Department of Health and Social Care, further details of which are explained in note 27.3 to these accounts. The Trust no longer has access to the ITFF working capital facility as at 31st March 2022 (and at 31st March 2021).

Note 24 Trade and other payables

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Current				
Trade payables	8,956	7,867	8,956	7,867
Capital payables	13,641	10,789	13,641	10,789
Accruals	32,738	32,485	32,734	32,487
Social security costs	5,981	5,783	5,981	5,783
Other taxes payable	46	43	0	0
PDC dividend payable	0	90	0	90
Other payables *	5,717	4,758	5,616	4,663
Total current trade and other payables	**67,079**	**61,815**	**66,928**	**61,679**
Of which payables to NHS and DHSC group bodies:				
Current	4,546	8,583	4,546	8,583

* Other Payables includes £3,880,000 (2020/21 £3,617,000) outstanding pension contributions as at 31 March.

Note 25 Early retirements in NHS payables above

	Group and Trust			
	31 March 2022 £000	31 March 2021 £000	31 March 2022 Number	31 March 2021 Number
years	0	0		
- number of cases involved			-	-

Note 26 Other liabilities

	Group and Trust	
	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income : contract liabilities	10,293	7,795
Total other current liabilities	**10,293**	**7,795**

Note 27 Borrowings

		Group and Trust	
	Note	31 March 2022 £000	31 March 2021 £000
Current			
Loans from DHSC	27.3	4,034	4,991
Obligations under finance leases	28.2	2,130	2,078
Obligations under PFI or other service concession contracts (excl. lifecycle)	34.1	1,312	1,166
Total current borrowings		**7,476**	**8,235**
Non-current			
Loans from DHSC	27.3	25,209	29,076
Obligations under finance leases	28.2	7,841	9,747
Obligations under PFI or other service concession contracts	34.1	15,288	16,600
Total non-current borrowings		**48,338**	**55,423**

Note 27 Borrowings - continued

Note 27.1 Borrowings - Reconciliation of liabilities arising from financing activities 2021/22 (Group & Trust)

	Total from financing activities £000	DHSC loans £000	Finance Leases £000	PFI obligations £000
Carrying value at 1 April 2021	63,658	34,067	11,825	17,766
Cash movements:				
Financing cash flows - payments and receipt of principal *	(7,935)	(4,805)	(1,964)	(1,166)
Financing cash flows - payments of interest - excludes contingent rent	(2,339)	(833)	(415)	(1,091)
Non-cash movements:				
Additions	126		126	0
Application of effective interest rate	2,304	814	399	1,091
Carrying value at 31 March 2022	**55,814**	**29,243**	**9,971**	**16,600**

* - Additions for DHSC cash flows are netted off within 'Financing cash flows principal'

Note 27.2 Borrowings - Reconciliation of liabilities arising from financing activities 2020/21 (Group & Trust)

	Total from financing activities £000	DHSC loans £000	Finance Leases £000	PFI obligations £000
Carrying value at 1 April 2020	103,948	79,242	6,086	18,620
Cash movements:				
Financing cash flows - payments and receipt of principal *	(47,174)	(45,086)	(1,234)	(854)
Financing cash flows - payments of interest - excludes contingent rent	(2,395)	(1,033)	(201)	(1,161)
Non-cash movements:				
Additions	6,963		6,963	0
Application of effective interest rate	2,316	944	211	1,161
Carrying value at 31 March 2021	**63,658**	**34,067**	**11,825**	**17,766**

* - Additions for DHSC cash flows are netted off within 'Financing cash flows principal'

Note 27 Borrowings - continued

Note 27.3 Loans from DHSC

The interest rates and terms of the Loans from DHSC are as follows: -

	Group and Trust								
	Total principal and interest outstanding at 31 March 2022	Interest Rate	Interest outstanding at 31st March 2022 and repayable within one year	Loan principal due within one year	Total current liability as at 31st March 2022	Loan principal repayments due after more than one year at 31 March 2022	Duration of Loan	Date of final loan repayment	Total outstanding at 31 March 2021
	£000	%	£000	£000	£000	£000	Years	£000	£000
Loans for Capital Developments									
Backlog Maintenance 2011/12	4,918	3.41%	48	540	588	4,330	20	Dec 2030	5,464
Backlog Maintenance 2012/13	5,287	1.90%	4	527	531	4,756	20	Mar 2032	5,815
Pharmacy Manufacturing Freehold	4,732	2.99%	5	411	416	4,316	20	Sep 2033	5,143
Pharmacy Manufacturing Fit-out	951	3.14%	1	950	951	0	12	Sep 2022	2,841
Critical Care Unit and Hospital Front Entrance	9,247	2.34%	78	706	784	8,463	20	Nov 2034	9,959
Linear Accelerator Bunker and associated enabling works	2,463	2.34%	21	188	209	2,254	20	Nov 2034	2,652
Replacement Linear Accelerator	999	1.66%	6	331	337	662	10	Feb 2024	1,332
Car Parking Facilities	646	1.66%	4	214	218	428	10	Nov 2024	861
Interim loan for Theatre Ventilation works *		0.78%		0	0	0	1	Sept 2020	0
Sub-total; Capital loans	**29,243**		**167**	**3,867**	**4,034**	**25,209**			**34,067**
Other Loans									
Working Capital Facility *	0	1.47%	0	0	0	0	10	Sep 2025	0
Revolving Working Capital Facility *	0	3.50%	0	0	0	0	5	Sept 2020	0
Interim Revenue Facilities *	0	3.50%	0	0	0	0	1	Sep 2020	0
Sub-total; Other loans	**0**		**0**	**0**	**0**	**0**			**0**
Total	**29,243**		**167**	**3,867**	**4,034**	**25,209**			**34,067**

	31 March 2022			31 March 2021
	Total	Interest	Principal	Total
	£000	£000	£000	£000
of which payable within: -				
- not later than one year;	**4,034**	**167**	**3,867**	**4,991**
- later than one year and not later than five years;	**10,578**	**0**	**10,578**	**19,220**
- later than five years.	**14,631**	**0**	**14,631**	**9,856**

* During 2020/21 the Department of Health wrote off a substantial value of NHS Provider debt. This included converting Interim capital loans, Interim Revenue loans, Working Capital facilities and Revolving Working Capital facility loans to Public Dividend Capital (PDC). Interest due on these loans was also frozen at 31st March 2021, the sum of which for this Trust amounted to £68k. The principal outstanding on these loans as at 31st March 2020 totalled £40,281k. PDC to this same value was received during September 2020 and the loans repaid in full. The value of the outstanding interest £68k was also repaid during 2020/21.

Note 28 Finance leases

Note 28.1 Finance Lease as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Gross lease receivables	**2,717**	**2,777**
of which those receivable:		
- not later than one year;	59	59
- later than one year and not later than five years;	238	238
- later than five years.	2,420	2,480
Unearned interest income	(2,216)	(2,275)
Net lease receivables	**501**	**502**
of which those receivable:		
- not later than one year;	0	0
- later than one year and not later than five years;	3	2
- later than five years.	498	500
The unguaranteed residual value accruing to the lessor	0	0
Contingent rents recognised as income in the period	0	0

The finance lease receivables relates to the lease of three properties to the South West Ambulance Service NHS Foundation Trust, two of which expire in 2090 and one in 2071, and the lease of part of the Torbay Hospital Annexe site to South Devon College which expires in 2063.

Note 28.2 Finance Lease as a lessee

Obligations under finance leases where the trust is the lessee.

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**10,728**	**12,885**
of which liabilities are due:		
- not later than one year;	2,419	2,428
- later than one year and not later than five years;	7,431	8,594
- later than five years.	878	1,863
Finance charges allocated to future periods	(757)	(1,060)
Net lease liabilities	**9,971**	**11,825**
of which payable:		
- not later than one year;	2,130	2,078
- later than one year and not later than five years;	6,974	7,925
- later than five years.	867	1,822
Total of future minimum sublease payments to be received at the reporting date	**0**	**0**
Contingent rent recognised as an expense in the period	0	0

The finance lease repayables relate to the lease of vehicles (including the Trust's Patient Trust Ambulance fleet), IT equipment and medical equipment.

Note 29 Provisions

	Group and Trust					
Group and Trust	Pensions : early departure costs	Pensions : Injury benefits	Legal claims	Clinician Pension Tax reimbursement	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**954**	**4,464**	**181**	**915**	**0**	**6,514**
Change in the discount rate	11	151	0	0	**0**	**162**
Arising during the year	50	185	102	0	**435**	**772**
Utilised during the year	(105)	(225)	(43)	0	**0**	**(373)**
Reversed unused	(47)	(108)	(13)	(415)	**0**	**(583)**
Unwinding of discount	(12)	(58)	0	0	**0**	**(70)**
At 31 March 2022	**851**	**4,409**	**227**	**500**	**435**	**6,422**
Expected timing of cash flows:						
- not later than one year;	**78**	**162**	**227**	**0**	**0**	**467**
- later than one year and not later than five years;	**312**	**648**	**0**	**28**	**0**	**988**
- later than five years.	**461**	**3,599**	**0**	**472**	**435**	**4,967**
- Sub-total; more than one year	**773**	**4,247**	**0**	**500**	**435**	**5,955**
Total	**851**	**4,409**	**227**	**500**	**435**	**6,422**

The provision entitled 'pensions early departure costs' has two components. The provision for early retirement and injury

The provision entitled 'legal claims' relates to personal injury claims received from employees and members of the public. These claims have been quantified according to the guidance received from the NHSLA and the relevant insurance companies. Due to the inherent uncertainty of this type of claim it has been assumed that any of the claims dealt with by the insurance companies will be settled and paid during the year ending 31 March 2022. The potential liability has been split into two parts with one part being provided for and the second part included in Contingencies at Note 31.

The provision entitled 'Clinician Pension Tax reimbursement' relates to a potential liability that the Trust will face to underwrite the tax liability faced by clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. The Trust will make a contractually binding commitment to pay clinicians in this position a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect in retirement. Due to the timescale for pension tax annual allowance (AA) charges and the scheme pays nominations, there is no data of the ‘actual’ nominations for the 2019-20 tax year available; the deadline for initial nomination is 31 July 2021, with the ability to make changes up to 31 July 2024. The Trust has recognised a provision liability in line with the estimate provided to the Trust by NHS England. The Trust's liability to these costs have been underwritten by NHS England and therefore a corresponding Receivable has been included in note 21 to these financial statements

Note 30 Clinical negligence liabilities

At 31 March 2022, £159,161k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Torbay and South Devon NHS Foundation Trust (31 March 2021: £93,668k).

Note 31 Contingent assets and (liabilities)

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Value of contingent (liabilities)		
NHS Resolution legal claims	(87)	(80)
Employment tribunal and other related litigation	(4)	0
Other	(1,485)	(1,567)
Gross value of contingent (liabilities)	**(1,576)**	**(1,647)**
Amounts recoverable against liabilities	0	0
Net value of contingent (liabilities)	**(1,576)**	**(1,647)**
Net value of contingent assets	**0**	**0**

Personal Injury Claims

The Trust receives a number of personal injury claims from employees and members of the public. The NHS Resolution administer the scheme and provide details of the liability and likely value of claims. The value of the claims which have been assessed as being unlikely to succeed for which no provision has been made in the accounts is £87,000 (2020/21 £80,000).

Employment tribunal and other related litigation

At 31 March 2022, there were two such cases ongoing. Taking into account both the potential liability (where this information is available) and the assessed likelihood of a liability arising, a contingent liability of £10,000 (2020/21: £0) is disclosed.

Centre for Health & Care Professions - South Devon College

The Trust entered into a lessor finance lease South Devon College on 1st September 2017 to enable the College to use part of the Trust's Torbay Hospital Annexe site as an educational facility. The Secretary of State for Education loaned the College a sum of money to invest in the site. This external investment does not form part of the Trust's Statement of Financial Position, but the value of the Trust buildings now leased to the College have been classified in the Trust's accounts as a finance lease. The lease is for a 50 year period, with a break point at year 30. If during the course of the primary lease period (i.e. the first 30 years) South Devon College (or successor organisation) was to cease the delivery of education (for whatever reason), then the Trust would be obliged to pay a sum to the Secretary of State for the capital invested by he Department of Education. The potential sum payable diminishes over time but at 31st March 2022 the potential liability would be £1.5m (31st March 2021 £1.6m). No provision for this potential liability has been made, as the likelihood of this liability crystallising is considered remote.

Note 32 Contractual capital commitments

	Group & Trust	
	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	11,453	8,519
Intangible assets	316	44
Total	**11,769**	**8,563**

Note 33 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
not later than 1 year	18,019	10,528	17,969	10,462
after 1 year and not later than 5 years	0	0	0	0
paid thereafter	0	0	0	0
Total	**18,019**	**10,528**	**17,969**	**10,462**

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has two PFI contracts for two Community Hospital facilities, namely Dawlish Community Hospital and Newton Abbot Community Hospital. Both contracts meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, and are therefore accounted for as 'on-Statement of Financial Position'

Dawlish Hospital

Dawlish Hospital has a value of £302k at 31st March 2022 (31st March 2021 £448k)

The Trust entered into an agreement under the Private Finance Initiative (PFI) arrangements for the construction of a new community hospital in Dawlish. The contract for the arrangement runs from 22nd June 1999 with a term of 25 years.

On 1 April 2002 this arrangement passed to Teignbridge Primary Care Trust (a predecessor body of Northern, Eastern and Western Devon CCG). On 1 April 2013 it passed to Torbay and Southern Devon Health and Care NHS Trust. On 1 October 2015 it returned to the Trust through the transfer of absorption of Torbay and Southern Devon Health and Care NHS Trust.

From the commencement of the contract a service fee of £241,000 was payable each year subject to indexation based upon RPI.

For the twelve month period 2020-21 that the Trust operated the scheme the unitary payment was £1,206k (2020-21 £1,131k)

Arrangement - The contract is for the provision of services for maintenance, domestics and catering staff for the hospital. The ownership of the equipment and content rests with the Trust. The arrangement works on the principal of 'no hospital, no fee'. The provision of services is managed through service level agreements, which have measurable targets and are subject to regular monitoring.

Terms of Arrangement - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPIX) All items, excluding mortgage interest payments'. Services are subject to market testing approximately every 5 years, and increases and decreases in costs from these regular market testing exercises are passed through to the Trust. At the end of the project term the Trust may allow the lease to expire with no compensation payable, or the parties may agree commercial terms for an extension of the agreement for a further 10 years, or have an option to acquire the leasehold interest and collapse the entire Lease structure by paying open market value for the land and buildings. In the event of re-financing of the PFI the Trust is entitled to receive half of the refinancing cash flow benefits. The Trust has now served notice on the PFI Operator that it intends to purchase the freehold from the Operator at the end of the current PFI term, i.e. June 2024.

Newton Abbot Hospital

On 11th April 2007 Devon Primary Care Trust (now reconfigured and named NHS Devon CCG) entered into an agreement under the Private Finance Initiative (PFI) arrangement for the construction of a new community hospital at Jetty Marsh, Newton Abbot. The capital value of the scheme was £21,980,000

The construction of the hospital was completed on 18th December 2008. From that date the unitary payment was £2,103,669 each year subject to annual RPI indexation movement for a period of 30 years. For the twelve month period in 2021-22 the unitary payment was £2,952k (2020-21 £2,913k). Newton Abbot Hospital has a value of £17,296k at 31st March 2022 (31st March 2021 £16,661k).

Arrangement - The contract is for the provision of maintenance services for this hospital. The ownership of the equipment between the parties is specified in the Agreement. The arrangement works on the basis of a reduction in the payments for failure to deliver to the agreed service levels. The provision of services is managed through service level agreements which have measurable targets and are subject to regular monitoring.

Terms of Arrangement - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements, continued

Note 34.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	Group and Trust			
	31 March 2022			31 March 2021
	Dawlish	Newton Abbot	Total	Total
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**1,495**	**24,283**	**25,778**	**28,035**
Of which liabilities are due				
- not later than one year;	743	1,568	2,311	2,257
- later than one year and not later than five years;	752	5,331	6,083	7,065
- later than five years.	0	17,384	17,384	18,713
Finance charges allocated to future periods	(224)	(8,954)	(9,178)	(10,269)
Net PFI, LIFT or other service concession arrangement obligation	**1,271**	**15,329**	**16,600**	**17,766**
- not later than one year;	603	709	1,312	1,166
- later than one year and not later than five years;	668	2,235	2,903	3,614
- later than five years.	0	12,385	12,385	12,986

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group and Trust			
	31 March 2022			31 March 2021
	Dawlish	Newton Abbot	Total	Total
	£000	£000	£000	£000
Total future payments committed in respect of the PFI service concession arrangements	2,732	63,005	65,737	68,679
Of which liabilities are due:				
- not later than one year;	1,288	3,193	4,481	4,156
- later than one year and not later than five years;	1,444	13,504	14,948	15,238
- later than five years.	0	46,308	46,308	49,285

The values of the above total future obligations include estimated allowances for the impact of future inflation that will be applied to the variable elements of the two PFI contracts. Assumptions made are that RPI and RPIX annual inflation will increase by circa 8.2% for 2022/23, 2.6% per annum for 2023/24 and 2.0% per annum thereafter, the latter two rates being provided by HM Treasury.

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust			
	31 March 2022			31 March 2021
	Dawlish	Newton Abbot	Total	Total
	£000	£000	£000	£000
Unitary payment payable to service concession operator				
Consisting of:				
- Interest charge	195	896	1,091	1,161
- Repayment of finance lease liability	502	664	1,166	854
- Service element and other charges to operating expenditure	414	523	937	1,083
- Capital lifecycle maintenance	0	0	0	100
- Revenue lifecycle maintenance	95	207	302	291
- Contingent rent	0	662	662	555
- Addition to lifecycle prepayment	0	0	0	0
Total Unitary payment	**1,206**	**2,952**	**4,158**	**4,044**
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	0	15	15	30
Total amount paid to service concession operator	**1,206**	**2,967**	**4,173**	**4,074**

Note 35 Financial instruments

Note 35.1 Financial risk management

A financial instrument is a contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another enterprise.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The financial assets and liabilities of the Trust are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other receivables. Surplus operating cash is only invested with UK based Clearing banks. The Trust's cash assets are held with National Westminster Bank plc., the Office of the Government Banking Service and Citibank only. An analysis of receivables and provision for impairment can be found at note 21, trade and other receivables.

Because of the continuing service provider relationship that the Trust has with local clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of credit risk faced by many other business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

Liquidity risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

The Trust's net operating costs are incurred largely under annual service agreements with local clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has secured eight Independent Trust Financing Facility (ITFF) Loans, details of which are disclosed in note 27 to the accounts. These loans were used to enable the Trust to invest in replacement infrastructure of Torbay Hospital, namely investment in backlog maintenance; enabled the expansion of the Trusts Pharmacy Manufacturing Unit (PMU); construction of a new Critical Care Unit and Hospital Front Entrance; improvement of Car Parking Facilities and continuation of the Trust's Radiotherapy service. Interest on these loans are fixed. The loan principal repayment and interest rates on these loans are disclosed in note 27.3.

During 2015/16 the Trust acquired two Private Finance Initiative (PFI) contracts, in respect of Newton Abbot and Dawlish community hospitals. Further details of the contracts are given in Note 34. The unitary payments for the Newton Abbot contract are subject to annual indexation in accordance with RPI (excluding mortgage interest payments). However, the associated risk is not judged to be significant, as these payments are equivalent to less than 1% of Trust turnover. With regard to the Dawlish contract, the availability fee is fixed and the service fee is subject to periodic market testing (meaning that the cost should be no greater than if the contract did not exist and the services were purchased externally).

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balance, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash flows are substantially independent of changes in market interest rates. Therefore, the Trust is not exposed to significant interest-rate risk.

Note 35.2 Carrying values of financial assets

	Group 31 March 2022		Group 31 March 2021	
	Held at amortised cost	Total book value	Held at amortised cost	Total book value
	£000	£000	£000	£000
Carrying value of financial assets as at 31 March under IFRS 9				
Trade and other receivables (excluding non financial assets)	21,812	21,812	16,772	16,772
Other investments / financial assets	2,452	2,452	752	752
Cash and cash equivalents	39,342	39,342	45,445	45,445
Total	**63,606**	**63,606**	**62,969**	**62,969**

	Trust 31 March 2022		Trust 31 March 2021	
	Held at amortised cost	Total book value	Held at amortised cost	Total book value
	£000	£000	£000	£000
Carrying value of financial assets as at 31 March under IFRS 9				
Trade and other receivables (excluding non financial assets)	21,842	21,842	17,213	17,213
Other investments / financial assets	2,827	2,827	752	752
Cash and cash equivalents	39,008	39,008	45,212	45,212
Total	**63,677**	**63,677**	**63,177**	**63,177**

Note 35.3 Carrying values of financial liabilities

	Group		Trust	
	Held at amortised cost		Held at amortised cost	
Other financial liabilities	31st March 2022 £000	31 March 2021 £000	31st March 2022 £000	31 March 2021 £000
Liabilities as per SoFP				
Loans from the Department of Health and Social Care	29,243	34,067	29,243	34,067
Obligations under finance leases	9,971	11,825	9,971	11,825
Obligations under PFI, LIFT and other service concession contracts	16,600	17,766	16,600	17,766
Trade and other payables excluding non financial liabilities	57,778	51,889	57,883	51,982
Total	**113,592**	**115,547**	**113,697**	**115,640**

Note 35.4 Maturity of financial liabilities

	Group		Trust	
	31st March 2022 £000	31 March 2021 £000	31st March 2022 £000	31 March 2021 £000
In one year or less	67,248	62,400	67,143	62,307
In more than two years but not more than five years	26,157	30,085	26,157	30,085
In more than five years	34,186	39,290	34,186	39,290
Total	**127,591**	**131,775**	**127,486**	**131,682**

In accordance with IFRS 7, the prior year comparatives have been restated on the basis of undiscounted future contractual cashflows.

Note 35.5 Fair Values

The book value of assets and liabilities (excluding loans from the Department of Health and Social Care) due after 12 months is estimated to be the same as the fair value of the assets and liabilities.

The fair value of Loans from the Department of Health and Social Care should be classed as being held at Current Value. They are however currently reflected at Amortised Cost. The valuations of these loans are again estimated to be the fair value of these loans.

Note 36 Losses and special payments

Group and trust	2021/22 Total number of cases Number	2021/22 Total value of cases £000	Restated * 2020/21 Total number of cases Number	Restated * 2020/21 Total value of cases £000
Losses				
Cash losses	10	3	5	6
Bad debts and claims abandoned **	195	302	166	2,424
Stores losses and damage to property	6	1	9	16
Total losses	**211**	**306**	**180**	**2,446**
Special payments				
Ex-gratia payments ***	21	12	17	1,045
Total special payments	**21**	**12**	**17**	**1,045**
Total losses and special payments	**232**	**318**	**197**	**3,491**
Compensation payments received		0		0

*Restated - The comparative value for 2020/21 has been restated to include a value of £1,037k for Overtime Corrective payments. This disclosure is now required by the 2021/22 Government Accounting Manual (GAM). A sum of £1,095K was accrued for as at 31st March 2021 but the ultimate payment made in 2021/22 totalled £1,037k. Please see supporting text *** below.

** Included with Bad debts and claims abandoned in 2020/21 was a sum of £2,212k relating to an income assumption made in previous years that remained unpaid at 31st March 2020. After reviewing the supporting documentation and discussing the position with one of the Trust's commissioner of services, the Trust concluded that the debt should be written off. A full provision for this bad debt was made at 31st March 2020 and therefore the net impact upon the Trust's Statement of Comprehensive Income result in 2020/21 was £0k.

*** Included within Ex-gratia payments in 2021/22 is a sum of £0k (2020/21 £1,037k) for Overtime corrective payments, this being associated with the 'Flowers and Others v East of England Ambulance Trust (2019) EWCA Civ947' legal case.

Note 37 Related parties

Torbay and South Devon NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. The Foundation Trust forms part of the Government's 'Whole Government Accounting' framework along with other NHS and Local Authority bodies. The Trust's parent is the Department of Health and Social Care and the ultimate parent is HM Government

Note 37.1 Related parties - Key Management (Group and Trust)

Key Management personnel - Key management includes directors, both executive and non-executive. The compensation paid or payable in aggregate to Key management for employment services is shown in the Annual Report and summarised in Note 5 to the Accounts 'Operating Expenditure'. None of the Key management personnel received an advance from the Trust. The Trust has not entered into any guarantees of any kind on behalf of Key management personnel. There were no amounts owing to Key management personnel at the beginning or end of the financial year.

During 2021/22 and 2020/21 the Trust transacted with related parties on whose Boards the Trust's non-executive directors and directors had similar chair or non-executive roles, or other interests. The value of transactions entered into were as follows: -

	Income 2021/22 £000	Income 2020/21 £000	Receivables 31 March 2022 £000	Receivables 31 March 2021 £000
Cornwall Care Ltd	0	11	0	11
	0	**11**	**0**	**11**

	Expenditure 2021/22 £000	Expenditure 2020/21 £000	Payables 31 March 2022 £000	Payables 31 March 2021 £000
Age UK Torbay	144	146	0	0
Devon Care Homes Collaborative Ltd	18	0	18	0
JSL Consulting & Associates Ltd	1	0	0	0
	163	**146**	**18**	**0**

Note 37 Related parties (continued)

Note 37.2 Non-consolidated Associates & Joint Ventures (Group and Trust)

	Income		Receivables	
	2021/22	2020/21	31 March 2022	31 March 2021
	£000	£000	£000	£000
Health and Care Innovations LLP	0	37	0	88
SDH Innovations Partnership LLP	0	4	0	0
	0	**41**	**0**	**88**

	Expenditure		Payables	
	2021/22	2020/21	31 March 2022	31 March 2021
	£000	£000	£000	£000
Health and Care Innovations LLP	214	373	18	228
SDH Innovations Partnership LLP	2,025	124	0	30
	2,239	**497**	**18**	**258**

The Trust sold its' equity stake in Health and Care Innovations LLP during the course of 2021/22 and the asset is now classed as an Asset held for sale as at 31st March 2022

The transactions with SDH Innovations Partnership LLP mostly relate to the construction of Land excluding Dwellings projects. SDH Innovations Partnership LLP's registration is OC424178. Its registered office is, 9th Floor Cobalt Square, 83-85 Hagley Road, Birmingham, United Kingdom, B16 8QG.

Note 37.3 Related Parties - Charity (Group and Trust)

The Trust also receives charitable contributions from a number of generous charitable and other bodies. These are channelled through Torbay and South Devon NHS Charitable Fund, for which the Foundation Trust is Corporate Trustee. The registered number of the charity is 1052232, the registered office is Regent House, Regent Close, Torquay TQ2 7AN. During the year, the Trust received revenue contributions of £934,000 (2020/21: £981,000) and capital of £252,000 (2020/21: £86,000) from the charity. The charity had reserves of £1,760,000 as at 31st March 2022 and recorded a decrease in funds of £149,000 during the year ended 31st March 2022. The balance of receivables due from the charity at 31st March 2022 was £49,000 (31st March 2021 £76,000).

Note 37.4 Consolidated Subsidiary (Trust)

	Income		Receivables	
	2021/22	2020/21	31 March 2022	31 March 2021
	£000	£000	£000	£000
SDH Developments Ltd	406	496	412	449
	406	**496**	**412**	**449**

	Expenditure		Payables	
	2021/22	2020/21	31 March 2022	31 March 2021
	£000	£000	£000	£000
SDH Developments Ltd	11,406	10,324	951	938
	11,406	**10,324**	**951**	**938**

SDH Developments Ltd is a company registered in the UK. Its registration number is 08385611 and its registered address is Regent House, Regent Close, Torquay, TQ2 7AN.

Note 37 Related parties (continued)

Note 37.5 Related Parties -Whole Government Accounting (Group and Trust)

During the year Torbay and South Devon NHS Foundation Trust has had a number of material transactions with the Department of Health and Social Care (DHSC) and other entities for which DHSC is regarded as parent of those entities. Income from these DHSC entities are reported in either note 3 - Operating Income or note 4 - Other Operating Income to these financial statements. Expenditure with these entities forms part of the Trust's Operating Expenditure - note 5 to these financial statements.

The DHSC Related Party transactions that are the most material in value to Torbay and South Devon NHS Foundation Trust and the nature of the primary relationship are described below

Devon Partnership NHS Trust	Principle sub-contractor to the provision of the Children's & Family Health Devon contract
Health Education England	Provide income to the Trust to facilitate the delivery of training to healthcare staff
NHS Devon CCG	The Trust's main commissioner of patient care services.
NHS England	Main commissioner of specialised and high cost services provided by the Trust
NHS Resolution	Provision of litigation cover
Northern Devon Healthcare NHS Trust)	Provision of clinical, internal audit and other services to one another
Royal Devon and Exeter NHS Foundation Trust)	
University Hospitals Plymouth NHS Trust)	
NHS Pension Scheme	Provision of post employment benefits to Staff and Directors of the Trust