Royal Devon and Exeter NHS Foundation Trust

From 1 April 2022 now known as the
Royal Devon University Healthcare NHS Foundation Trust

Annual Report and Accounts 2021/22

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CONTENTS

CHAIR'S INTRODUCTION

I became Chair of the newly merged Royal Devon University Healthcare NHS Trust as it launched on 1 April 2022 following the integration of Northern Devon Healthcare NHS Trust (NDHT) and the Royal Devon and Exeter NHS Foundation Trust (RD&E). Whilst I was not in my role during the 2021/22 financial year, I have read this report with great attention, and the information outlined within it has formed an important part of my induction into the organisation.

I wanted to start with a huge thank you to all of our staff and volunteers for everything they do. We have emerged from another difficult year of the pandemic, and our staff and services have experienced significant pressure. I know that it has often felt extremely challenging and colleagues have been concerned that they can't achieve everything they would like to. But I believe our team should take pride in everything they do, knowing that they are doing the very best they can for our patients.

Our teams have achieved a great deal this year. As well as working incredibly hard and flexibly to provide care, they have played a crucial role in the COVID-19 vaccination campaign, leading our centres and administering the vaccine, ensuring people across North, Mid and East Devon are given the opportunity to be vaccinated – and this important work continues.

Our teams have also worked hard across all of our services to address our waiting lists. The Nightingale Hospital Exeter has increased the capacity across Devon for planned care. Our staff and those at our partner organisation have transformed the space from a COVID-ward into a diagnostic and treatment centre providing orthopaedic, ophthalmology, rheumatology and diagnostic services, and we are proud to see fantastic patient feedback for the facility. Following significant planning and construction work this year, a new modular theatre will also open at North Devon District Hospital in May 2022 which will provide beds for orthopaedic surgery.

In July, following a significant programme of work from our teams, we will be able to rollout our Epic electronic patient record in Northern Devon, which means we will have a shared patient record system across all our services. In North Devon, during 2021/22 we developed our plans for renewing North Devon District Hospital, as a result of its inclusion in the Government's New Hospitals Programme. These programmes of work will provide fantastic opportunities for our staff and patients, helping us to modernise and improve the way we deliver care.

Before I finish, I wanted to take the time to thank my predecessor, James Brent. James was an outstanding Chair at the RD&E for ten years and chair at NDHT for four years. He leaves the successful integration as part of his legacy.

It was clear to me in taking this role that the merger is the right thing for the people of North and East Devon. Formally bringing our organisations together unlocks opportunities to improve the resilience and sustainability of the healthcare we deliver to our patients across all of the areas we serve, from North, to Mid, to East Devon. As a newly merged Trust and as we move towards living with COVID, we have the opportunity to reset our services and set out our plan to recover for the future.

There will of course continue to be challenges ahead, but with our amazing staff and volunteers, and the support of our communities, as well as our important university and research partnerships, I am certain we have the best possible team to face them.

Dame Shan Morgan
Chair
Royal Devon University Healthcare NHS Foundation Trust

PERFORMANCE REPORT: OVERVIEW

Performance report overview introduction

The purpose of this overview is to provide a short summary that gives readers information about the Royal Devon and Exeter NHS Foundation Trust (RD&E), its purpose, the key risks to the Trust achieving its objectives and how it has performed during the year.

The RD&E is a Foundation Trust and, as such, we are legally required to produce an Annual Report and Accounts. We are obliged, by our regulators, to follow a clear structure and to ensure we include certain mandated information that sets out how we have performed during the preceding financial year and how we have used the resources available to us. Our focus in preparing this report has been to make sure that we give a true and accurate account of our work over the last financial year.

Introduction by the Chief Executive

Welcome to our Annual Report & Accounts for 2021/22

Our report looks back at the last 12 months, summarising our achievements and the challenges we faced, and looks forward to what we would like to achieve over the course of the next financial year.

The ongoing COVID-19 pandemic has dominated this past year, but once again the Trust's staff have risen to the challenge magnificently, with unflinching resolve, professionalism, compassion and sometimes much-needed humour, in the face of extremely difficult circumstances. The pressures that COVID-19 has placed on our ability to care for our patients, has tested us sometimes to the limit.

I am very proud to say that, despite the staffing challenges we face, with high levels of staff absence due to COVID-19 and ongoing recruitment issues affecting Trusts across the country, we have continued to deliver safe and compassionate care during the past year to tens of thousands of people across our area who depend upon us in so many different ways.

The COVID-19 vaccination roll out has been a key focus for us during the last 12 months. Getting vaccinated is the best protection we have against viruses like COVID-19 and Flu and also helps to minimise the number of hospital admissions due to these viruses, alleviating the pressure on our hospitals.

To date, over 2.7 million vaccines have been administered in Devon. Our staff and volunteers have played a really important part in achieving this remarkable feat, delivering vaccinations in our hospitals, in the centres at Greendale in Exeter and Barnstaple Leisure Centre, and in a number of other settings. Everyone over the age of 18 years has now been offered a second vaccine, and we are now spearheading a major campaign to maximise the uptake of booster jabs.

The pandemic has not only caused considerable pressure to our acute services, but has led to a backlog of elective care right across the country. Historically, we have had low waiting times, but we know more people are waiting longer for care than before, and for this we are sorry.

We are doing everything we can to recover our elective care services, and our plans include short, medium and longer-term programmes of work. This includes the Nightingale Hospital Exeter, which is providing elective care to patients across Devon, and a number of new initiatives, including opening a new-build elective ward at North Devon District Hospital.

And whilst COVID-19 remains, we are taking time to reset and look to the future. This will be the last annual report published by the RD&E as an organisation, as on 1 April 2022, the Trust merged with NDHT to become the Royal Devon University Healthcare NHS Foundation Trust.

With a combined budget of £865m for 2022/23, the new Trust has over 15,000 staff and provides core services to around 615,000 people. Together, we have ambitions to be a leading, digitally enabled teaching hospital Trust.

We successfully rolled out the Epic electronic patient record at RD&E in October 2020 and we plan to launch the system in Northern Devon in July 2022,

giving us a common electronic patient record across our services. This will help us to modernise the services we deliver to our patients, making the best use of digital technologies and helping to mitigate the rurality of our county.

On a personal note, I want to drive our inclusion work forwards in the coming year. We are striving to create a Trust that meets the needs of all of the people we serve and where everyone feels respected, regardless of who they are, what they look like or how they identify. We have an inclusion plan for 2022/23 which sets out our key priorities for the year and this is led by our Inclusion Steering Group, which I personally chair. I look forward to being able to update you on the work we have done next year.

Finally, I would like to express my enormous gratitude to the outgoing Chairman of the RD&E and NDHT, James Brent, who for a decade has provided leadership, wisdom and unstinting support during a time of unparalleled challenges and change. James leaves the successful integration of NDHT and the RD&E as his legacy, helping us to secure a better future together as the Royal Devon University Healthcare NHS Foundation Trust.

We are delighted to welcome Dame Shan Morgan as James' successor. Dame Shan started her role on 1 April 2022 and joins us at such an important and exciting time for our organisations. We know her expertise and passion for public service will be invaluable as we seek to develop our future direction and make a real difference for our communities and staff.

I want to finish by saying a final, huge thank you to our staff, volunteers, Council of Governors, members, patients and all of our stakeholders. Your dedication, skill and self-sacrifice, has helped us deliver the very best care and services we can to our patients over the past year.

I am extremely proud of all that we have achieved and truly believe that we are better together. I look forward to working with you all next year.

Kind regards,

Suzanne Tracey
Chief Executive Officer
Date: 08 June 2022

About the Royal Devon & Exeter NHS Foundation Trust

The RD&E provides a full range of health and care services to around 450,000 people across Eastern and Mid-Devon.

Our staff together to deliver integrated care across a number of sites, including a large acute hospital, twelve community hospitals, various community and primary care settings, and in people's homes.

The Trust has an international reputation for providing high quality healthcare services, and as a teaching hospital that delivers undergraduate clinical education, we aim to inspire the next generation of healthcare professionals and transform the way care is delivered to our local communities.

The RD&E became one of the first Foundation Trusts in 2004 and this status, together with accountability to local citizens through our membership and governors, means we are better able to respond to local needs and connect with the people and communities we serve.

Our Trust values were developed by our staff and form the cornerstone of all that we do, as individuals and as an organisation. Our values are:

- fairness
- honesty, openness & integrity
- respect & dignity
- inclusion & collaboration

Royal Devon and Exeter (Wonford) Hospital, Exeter

The Royal Devon and Exeter (Wonford) Hospital is our largest hospital in the Trust, where many of our acute clinical services are based, including our Emergency Department, Walk-in Centre and Minor Injuries Unit (MIU).

The hospital is home to a number of our highly acclaimed specialist units and centres, including:

- **The Princess Elizabeth Orthopaedic Centre:** our internationally renowned centre-which is widely recognised for its excellence and innovation-diagnoses, treats, and repairs bones, joints, muscles, ligaments and the spine.

- **The Centre for Women's Health:** our award-winning Maternity, Neonatal and Gynaecology services, which include specialist wards, operating theatres and the RD&E's birth centre and screening unit.
- **Mardon Neurorehabilitation Centre:** our purpose-built, 12-bed specialist neuro-rehabilitation inpatient unit, which is located near to the Wonford site.

Integrated health and social care community services

On any one day our community teams support up to 1,680 people to remain safe and well within the community setting. This support can be provided in a variety of ways including:

- any of our three community inpatient settings (Exmouth, Tiverton and Sidmouth) for short term reablement and rehabilitation
- in an outpatient clinical setting with our specialist services (MSK Physio, Podiatry, Ambulatory care, Chronic Fatigue, Specialist rehab/ nursing teams)
- who work flexibly across community sites and GP Practices
- within a patient's own home/place of residency (community nursing/matrons, Rehabilitation, Urgent Community Response)

Our teams work closely with a wide number of health and care professionals, including colleagues working in the acute hospital, social care, primary care, mental health and the voluntary sector to support people to self-manage their long-term conditions, improve their mobility and maintain their independence.

We also support people who have an urgent need to either avoid an unnecessary hospital admission or support people home from hospital who may need short term support until they regain their independence or for specialist end-of-life care. We manage a range of inpatient and outpatient services across East and Mid-Devon from 12 community hospital locations, which provide local hubs for our community's healthcare that are easily accessible to our local population. These span a wide geographical area, and include minor injuries units and a variety of outpatient services.

Our year in photos

South West Genomics Laboratory Hub team given 'Excellence in Healthcare Delivery' award

A team at the South West Genomics Laboratory Hub received national recognition for developing a diagnostic service that enables rapid identification of rare genetic diseases in acutely unwell children. The team developed a diagnostic technique that can analyse children's DNA and identify rare genetic disorders much quicker than was previously possible.

More than one million COVID-19 vaccine doses given in Devon

Thanks to the incredible efforts of health and care staff, volunteers and local communities, between December 2020 and May 2021, over 1 million doses were administered in Devon. The local vaccination programme worked tirelessly with all communities across Devon to increase take-up in a range of different demographic groups.

Volunteers' week 2021

In June we celebrated Volunteers' Week and shined a particular spotlight on Jack Carter, who in a year, volunteered more than 1,306 hours to the RD&E.

80-year-old Jack spent his life working in the construction industry, but says that without the skill and dedication of the surgeons at the RD&E who saved his hearing, he wouldn't have been able to enjoy a long and happy working life. So, Jack decided to give something back to the hospital, and has been volunteering for the past five years, working 6.45am to 11.30am, Monday to Friday, meeting, greeting and escorting patients.

RD&E celebrates 'miracle' babies

June 2021 marked the milestone of twenty-one 'miracle' babies born at the Trust since a service for couples with a high risk of having a child with a genetic disorder began in 2015. The service, which is run by the RD&E and is the only one in the South West, allows patients to have the majority of their treatment in Exeter rather than having to travel to London for multiple appointments.

Celebrating the NHS' 73rd birthday

5 July is the NHS birthday, and we used this special day as an opportunity to say a big thank you to our amazing staff who have cared for patients throughout the whole of the pandemic, and played a vital part in the biggest vaccination programme in our history.

RD&E staff meet the Prince of Wales

A group of Trust staff met HRH the Prince of Wales and HRH the Duchess of Cornwall at Exeter Cathedral. The royal couple shared their thanks and appreciation to all NHS staff for their hard work throughout the pandemic.

RD&E launches new rheumatoid arthritis support group

The RD&E and the National Rheumatoid Arthritis Society joined together to create the Exeter Area Rheumatoid Arthritis Group. The group meets regularly, offering mutual support and information for patients, with the aim of helping them live well with Rheumatoid Arthritis.

Exeter midwife wins national midwifery award

Midwife Liz Collins won the Chief Midwifery Officer's Silver Award in recognition of her major contribution to supporting vulnerable women and their babies at the Trust. The silver award celebrates performance that goes above and beyond the expectations of the everyday role that a nurse or midwife is expected to perform – well done Liz!

New artwork pays tribute to the work of RD&E staff during COVID-19 pandemic

A new piece of artwork, titled 'Not All Heroes Wear Capes', was unveiled in the main entrance of Wonford Hospital in recognition of the work undertaken by RD&E staff during the COVID-19 pandemic. It was donated to the Trust by June Gardener, who made the artwork as a personal 'thank you' after her mother spent time in Wonford Hospital last year.

RD&E chefs win the South West Regional NHS Chef of the year 2021 award

Chefs Giles Hensser and Martin Watts, of RD&E, won the South West Regional stage of the NHS Chef of the year 2021 award. Their winning challenge was to produce a starter, main course and a dessert, all of which had to be delicious, have the nutritional information stated and within a specific budget. Well done, team!

RD&E & DPT win the Health Service Journal Mental Health Initiative of the Year award

The 'Gastroenterology Big Room' project in Devon connects physical and mental health services to improve the experience of gastroenterology patients and addresses the long waiting times for psychological therapy for gastroenterology patients. The initiative was developed by the RD&E and Devon Partnership NHS Trust, and was named the Mental Health Initiative of the Year at the 2021 Health Service Journal Patient Safety Awards.

The NHS Nightingale Hospital Exeter wins award for collaboration project

Thousands of people played a crucial role in building the NHS Nightingale Hospital Exeter in 2020, which was set up to provide extra capacity to support existing NHS services across the region during the COVID pandemic in just 57 days. This achievement was recognised at the Institute of Civil Engineering South West Awards, where the Nightingale project team won the "Collaboration of the Year" category.

Blood Sciences Team wins Acute Sector Innovation of the Year award

A national at-home finger prick blood collection and testing service which gives patients greater control over their own health, designed and developed by the Blood Sciences Team at the RD&E, has won the Health Service Journal Acute Sector Innovation of the Year Award. Since the service went live in March 2021, the team has performed over a thousand tests for clinical and research services.

Neuroimaging Centre opens on RD&E (Wonford) site

The University of Exeter Medical School's new Mireille Gillings Neuroimaging Centre opened on the RD&E Wonford site in March 2021. The new Centre will enable researchers to build on current clinical trial expertise through innovative use of state-of-the-art brain-scanning technology and techniques and become the leading clinical trial centre in Europe for trials focussing on Parkinson's disease, dementia, and brain health.

(Pictured-global business leader and philanthropist Lady Mireille Gillings who officially opened the new imaging centre)

RD&E significantly improves performance in National Children and Young People's Patient Survey

The Trust received significantly improved results in the latest Care Quality Commission Children and Young People's patient experience survey. The Trust's scores increased significantly in many key areas, all of which play an important contribution to patient experience. These results were a real testament to the hard work of the staff, and it's fantastic these improvements were recognised.

Dame Shan Morgan appointed Chair of RD&E and NDHT

Dame Shan will take on the role of Chair for an initial term of office of three years, and succeeds current Chairman James Brent. She has a wealth of experience from her career working in a variety of roles for the Foreign Office, and has held roles as HM Ambassador to Argentina and Paraguay, plus represented the UK in the European Union. In her previous role, Dame Shan was head of the Civil Service of the Welsh Government.

Maternity services at the RD&E rated highly by local mums

The Trust was rated 'highly' by local mums in the 2021 National Maternity Survey. The RDE was the tenth highest scoring Trust for overall positive results, and of the 35 categories, 33 were equal to or above the survey average.

Key developments

In 2021/22

- We cared for 106,855 inpatients, 42,608 day cases, and 694,563 outpatients
- Our Emergency Department had 90,906 attendances; our Minor Injuries Unit had 11,039 attendances; and our Walk-In Centre had 22,360 attendances.
- We looked after 116,685 people in our community hospitals
- 4,018 babies were delivered.

RD&E and NDHT integration

On 1 April 2022, the RD&E and NDHT merged to become The Royal Devon University Healthcare NHS Foundation Trust.

The two Trusts have been working together under a collaborative agreement since 2018, and started exploring a more formal partnership back in December 2019.

In late 2020, the RD&E and NDHT Boards agreed to start preparing to merge the Trusts and submit their Strategic Case to NHSEI. A full business case was submitted in December 2021.

The NDHT and RD&E Board and RD&E Council of Governors officially approved the merger on 22 March 2022, and NSHEI gave their approval shortly after. On 30 March 2022, the Secretary of State for Health and Social Care provided final approval for both Trusts to merge and become the Royal Devon University Healthcare NHS Foundation Trust on 1 April 2022.

Why integrate?

Like other NHS organisations up and down the country, the RD&E and NDHT face the challenges of limited resources, recruitment issues, increasing demand for our services, managing waiting lists, and responding to the COVID-19 pandemic.

Due to its unique geographical area, Devon faces a number of issues which impact on the health and wellbeing of the population and has significant health outcome and life expectancy inequalities. Over the last decade, meeting the health needs of the population in Eastern and Northern Devon in particular has become increasingly challenging and complex.

The integration of the Trusts unlocks opportunities to improve the resilience and sustainability of healthcare delivered to patients across Northern, to Mid, to Eastern Devon.

In particular, the future of care delivery within the Trusts will be transformed through the use of digital systems, and particularly our electronic patient record system, Epic. By removing the old traditional boundaries between organisations, patients and staff will experience a more joined up and consistent approach to healthcare.

In addition, as a single Trust, we will enhance how our teams collaborate in our strategic planning and day to day operational delivery. There will be more varied career options and the opportunity to gain additional experience, accessing a digital patient record system that will create more time for direct patient care, enhanced morale, a reduction in pressures on services and a culture of positive collaboration and shared problem solving.

Next steps

At the time of writing, the Trust had successfully integrated with NDHT, which formerly occurred on 1 April 2022, to become The Royal Devon University Healthcare NHS Foundation Trust. The new Trust has two acute hospitals, 17 community hospitals and a range of community, specialist and primary care services, cares. It has more than 15,000 staff, who work together to deliver core services for 615,000 people, and specialist services across the whole of the peninsula. The Trust will have an annual core budget of £864m. Over the next two to three years, teams will work together to merge their corporate and clinical services to serve our combined population.

Innovating in response to operational challenges

Over the last year, the Trust has had to continuously adapt to the shifting demands of the COVID-19 pandemic whilst recovering our elective services.

There have been many challenges to delivering these aims, including:

- high numbers of staff absence across all professional groups at the RD&E, as well as the wider health and social care system.
- the emergence of the Omicron variant, which led to significantly greater case numbers than previously modelled.
- the Trust's continued commitment to supporting system partners. This includes caring for COVID patients from other NHS organisations and accepting emergency department diverts from other acute Trusts.

In the face of these challenges, our staff and leadership teams have continued to show great innovation. A number of initiatives and programmes have been set up to support our operational resilience and ensure we can continue to provide excellent, high quality care to our patients, including:

- Creating a discharge lounge, which facilitates the earlier discharge of up to 30 patients every day, and which offers a restful environment for patients who are ready to go home. Staffed by registered nurses and HCAs, the Discharge Lounge team are able to assist with final discharge plans, such as finalising discharge summaries, checking that patients receive their medication, ordering transport and contacting the patient's family, friends or carer. Every patient who uses our Discharge Lounge helps another through releasing vital bed space, improving patient flow significantly and helping more patients to receive the right care, in the right place, at the right time.
- Expanding our perioperative medicine model across our surgical division to support greater care for emergency patients, and improve supervision and training opportunities of junior medical staff.
- Establishing new pathways for long COVID and rehabilitation across our community services, so that we can remain responsive to the health needs of local people and ensure that their care is provided close to, or in, their homes.
- Redeveloping our emergency department, with plans to include new minors, waiting and resuscitation areas underway.
- The introduction of a "Patient Flow Gold Command" which ran for ten weeks and addressed a number of operational challenges to patient flow. Outputs include a significant expansion in staffing levels in our Emergency Department, and the conversion of escalation beds into a medical ward, significantly increasing staffing resilience and the consistency of care.
- Creating a high-quality facility for the Plastic Surgery Trauma team which will help to expedite the discharge of patients from the Emergency Department.

- Working with partners to design and build a new vaccination centre at Greendale, relocating services from Westpoint Arena to our new site, and building a new entrance to the Greendale vaccination centre in just two days to make the site easier to access. Thanks to the hard work of our vaccination team, we have also held a number of pop-up clinics across Eastern Devon, helping to make our services more accessible to local people.
- Implementing state-of-the-art, market leading Haematology analysers with "digital morphology" capability. This has improved the quality of our services, freed up valuable time for clinical teams, and reduced the turnaround time to diagnosis from 45 minutes to 16 minutes. Cell images are now digital and can be viewed remotely from any PC as part of the Trust's continued digitisation of patient records.
- Using artificial intelligence called "Limbus AI Contour", we have been able to speed up the planning process for radiotherapy, reducing the average "contouring" time from 2 hours to just over 30 minutes per patient.
- Launching the "My Sunrise" app, which is a free information resource designed specifically to support patients through their cancer treatment journey.

Reducing our waiting lists to support long waiting patients

Reducing our waiting lists is a complex, wide-reaching and important task. In line with the publication of the national delivery plan for tackling the COVID-19 backlog of elective care, we have been working hard to develop an elective care recovery plan, which incorporates short, medium and longer term programmes of work. Our aim is to reduce waiting times for patients, and while they are waiting, to provide support to avoid them coming to harm and give them the best possible experience.

Supporting and involving our patients

- We are directly communicating with patients on our waiting lists to apologise for the delay, being honest and clear that we aren't in a position to offer them a date yet, and proactively asking them to let us know about any changes to their condition. This is supporting us in our continual clinical prioritisation processes, so that we can offer appointments in order of clinical urgency.
- We have published an open letter to patients that is available on our website and signposts patients to the Devon-wide My Health website, which includes an interactive map of waiting times in England. This is supported by information about preparing for appointments and surgery.
- We are continuing our rollout of patient-initiated follow-up (PIFU) across specialties, and our clinicians and patients are sharing the decision to be put on a PIFU pathway. Being on a PIFU pathway empowers patients to request follow-up care directly with the specialist team when they have concerns about their symptoms, rather than going through primary care. Our PIFU plans include seeking feedback from patients so we can learn and improve.
- We are continuing our focus on remote consultations, with the intention of procuring a Devon-wide video appointment platform for secondary care. We know from the feedback we receive that patients who have tried a video appointment really like them, plus it saves them money, time, worry and in some cases pain and discomfort of travelling to hospital for an outpatient appointment, so we will continue to promote these sessions to clinically appropriate patients.

Creating great spaces for care for Eastern Devon patients

- We have developed a one-stop urology cancer service which delivers outpatient appointments, cystoscopy, and biopsies in Ottery St Mary Community Hospital.
- We have created a new outpatient unit at the former Exeter Community Hospital with ten additional rooms, now providing services for a wide range of specialties
- Additional ophthalmology capacity at Axminster Hospital has been created for outpatients and day case procedures
- Following a successful bid for central capital, the Trust is converting space previously occupied by medical records into new facilities for our Preparation for Surgery Team, which will significantly increase capacity and help expedite surgical pathways.
- RD&E patients who meet certain criteria are being offered available Independent Sector capacity across the region (Exeter, Torbay, Plymouth), which may mean they can have their appointment sooner.

Using the NHS Nightingale Hospital Exeter for the people of Devon

The NHS Nightingale Exeter (Nightingale) was initially part of the national response to the first wave of the pandemic, providing emergency in-patient care for nearly 250 patients with COVID-19 from across Devon, Somerset and Dorset.

After being decommissioned as a COVID-19 hospital in March 2021, the Nightingale was purchased by the RD&E on behalf of NHS organisations across Devon and the South West region. The site has since been used to provide thousands of important diagnostic scans to local people and support the delivery of COVID-19 vaccine studies, as well as acting as a training centre to support new staff arriving from overseas.

In May 2021, it was announced that the Nightingale would receive a share of funding from the National Accelerator Systems Programme, which was awarded to Devon to support the reduction in waiting times.

As a result of a clinically led redesign programme, the Nightingale is now offering the following services to help further reduce waiting times:

- Southwest Ambulatory Orthopaedic Centre, which has two operating theatres for day case and short stay elective orthopaedic procedures
- Centre of Excellence for Eyes, which operates diagnostic screening services for ophthalmology patients and will run a high-volume cataract treatment hub
- Devon Diagnostic Centre, which is providing CT, MRI, X-ray, ultrasound, echocardiograms and fluoroscopy services
- The RD&E's Rheumatology department which provides outpatient care and day case infusions.

Paul White, from Fremington in North Devon, was the first patient to receive a hip replacement at the Nightingale. He said: "I've had an issue with my leg for the last 20 years or so – after seeing a doctor initially, I spent a year waiting to see a specialist consultant at NDHT and was put on a waiting list for surgery.

"Compared to many, I know I'm very lucky, as I was only on a waiting list for 6 months. But this surgery will change my life – I'm only 66 years old, and thanks to my hip replacement, my body will be able to act the age I feel. I am looking forward to being able to work as a taxi driver pain free for the first time in two decades, but most importantly, I can't wait to get back on my push bike!

"I'd like to say a huge thank you to the teams who performed my surgery and looked after me. I realise how lucky I am to get the operation. You've all given me a new lease of life – from the bottom of my heart, thank you so much."

Optimising Epic

Our Electronic Patient Record (EPR), Epic, went live across the RD&E on 7 October 2020, and work to optimise the system has been taking place ever since. Following the completion of this optimisation work, the benefits for patients and clinical staff will be considerable and includes enabling more face-to-face time with patients, enhanced patient safety and, in the near future, wearable technology that will send health data from patients to clinical staff.

Throughout this year, the team have enhanced the system based on our clinicians' feedback and commenced the pilot programme for our MY CARE Patient Portal app.

On any normal working day, over 2,500 members of staff will be simultaneously logged into, and using, our EPR. Over 30,000 patients have already registered to use our MyChart Patient Portal, allowing patients to access sections of their own records electronically.

On our wards, nurses and other staff no longer have to formally document care provided and patient observations, as Epic automatically records mandatory data. The need to repeatedly ask and document the same information is also no longer necessary as it remains stored in the system. This releases our staff to provide more face-to-face care directly to our patients.

We are also using our digital programme to enhance patient safety and drug administration, which provides added peace of mind for our patients.

In pilot areas, the MyChart app allows two-way communication between patients and their clinicians, and supports continuous health monitoring between formal outpatient appointments. We hope to develop this system further over the next 12 months to include wearable technology such as smart watches to automatically communicate health data between patients and clinical teams.

The My Chart Patient Portal is one of our priority development areas, with a goal of registering 100,000 patients by the end of 2022/23, and to implement an electronic 'self' booking service to give patients the opportunity to choose a convenient appointment timeslot themselves. It is our best opportunity to improve outpatient appointment services by empowering patients and ensuring

they can access the right clinicians in the right environment.

As we prepare to go live with Epic across Northern Devon in July 2022, we have worked to ensure that our clinical and administration teams are ready for one electronic health record to be instantly accessible by our clinicians for our patients.

The development of our Epic EPR is an exciting and innovative development in patient care, and we are now encouraging as many patients as possible to sign up to the MyCare Patient Portal.

The Green Plan – playing our part in reducing the impact of climate change

The national campaign for a 'greener' NHS was launched in January 2020 and is an hugely ambitious programme seeking to mobilise more than 1.3 million NHS staff and deliver plans for the NHS to reach net zero carbon emissions by 2040.

In January 2022, the RD&E and NDHT developed and agreed a joint Green Plan, which set out how both Trusts planned to achieve their long-term sustainability goals and 'Net Zero' targets. This Plan acts as a sustainability guide to the design and implementation of the newly integrated Trusts' future services, and will provide a strong foundation to ensure that these environmental ambitions are embedded into everything we do.

There is more information on this in our sustainability report on page 168.

Research and development

As a teaching and research Trust, research and development are pivotal activities in ensuring that our patients benefit from the latest technologies and techniques, and in attracting and retaining our enviable team of highly skilled staff. The Trust collaborates closely with the University of Exeter as well as working with other university and research partners across the UK and globally.

Together, the RD&E and University of Exeter College of Medicine and Health run the Joint Research Office (JRO), a leading centre for high quality research, development and innovation in the South West peninsula.

The JRO works hand-hand with the RD&E Innovation Hub and the University of Exeter's Innovation Impact and Business department, to bring health innovations to life for patients and businesses. This exciting relationship enables us to deliver outstanding and globally recognised research and innovation; transforming clinical care, technologies and medicines for people locally, nationally and worldwide.

One of the latest examples of the close partnership working between the University of Exeter and the RD&E is the new Mireille Gillings Neuroimaging Centre, which opened in March 2021 on the RD&E Wonford site. The new Centre will enable researchers to build on current clinical trial expertise through innovative use of state-of-the-art brain-scanning technology and techniques and become the leading clinical trial centre in Europe for trials focussing on Parkinson's disease, dementia, and brain health, helping to accelerate clinical trials for potential dementia treatments over the next five years.

During this past year there has been recruitment to over 140 unique studies, with research activity being delivered across the breadth of clinical specialties benefitting from support from the National Institute for Health and Care Research (NIHR) Exeter Clinical Research Facility (which has just been awarded core funding for a further five years), and the NIHR Exeter Patient Recruitment Centre, enabling us to work with commercial and non-commercial partners across the breadth of research development.

The Trust has continued to be at the forefront of the highly successful COVID-19 research programme, including our researchers from the Exeter Inflammatory Bowel Disease (IBD) Research Team leading the CLARITY IBD study, which recruited over 7,000 participants with inflammatory bowel disease in 12 weeks across 92 sites, and rapidly answered key questions about the impact of immunomodulator and biologic therapies on COVID-19 immunity following infection and vaccination.

The Trust also collaborated with research led by other sites, including GenOMICC, the world's largest study of the genetics of COVID-19, which has provided vital information about the most severe form of the disease. The Trust additionally supported a large programme of vaccine trials, including NOVAVAX, the COVID-19 vaccine trial, with over 95% of the RD&E's participants saying they would participate in research again, and multiple arms of the Cov Boost trial which has informed the national booster programme.

Our staff published over 300 publications and achieved considerable success with other projects led by our researchers, including the TriMaster trial led by Professor Andrew Hattersley. The study, which completed this year, has provided important information about the treatments used for Type

Il diabetes, with further work planned to develop a support tool for tailored treatment advice for patients.

Supporting our nurses, midwives and allied health professionals to engage with and lead research has also been a key focus of activity. We established an annual programme of Chief Nurse Research Fellows (CNRFs) within the Trust, aimed at supporting clinical staff new to research to undertake a bespoke training programme, including a project to improve patient care.

The Trust's first 'Embedding Research In Care' (ERIC) unit was launched in April 2021 in the respiratory department. This initiative, designed to support the integration of research into care, has to-date identified 14 clinical challenges now progressing as service evaluation, audit or research, supported by a research facilitator as well as having patient representatives as integral members of the oversight team.

Our academic departments continue as beacons of research and innovation. They have engaged effectively with Epic to support their research activity, including the emergency medicine department, which has designed and implemented a conditional pop-up to highlight potential patients for the ABCS sepsis trial, and the Orthopaedic department which has embedded their research and national registers within Epic, as well as integrating outcome scoring systems within routine follow up, and linking that with the MY CARE Patient Portal.

RD&E Charity update

RD&E Charity is the registered working name of the RD&E's general charity, independent registered charity no. 1061384. The charity supports the work of RD&E by investing in key areas such as equipment, patient and family support, capital projects, staff training and transforming our hospitals into more welcoming and comfortable environments. The charity funds above what the NHS is able to provide to make a real difference to the experience of patients, their families and the staff that treat them.

Many of our donors wish to give to an area close to their heart, especially those who have experienced our care or left money to us in their will. We gladly honour donor's wishes and maintain different funds allocated to particular wards, departments and services.

Our latest appeals

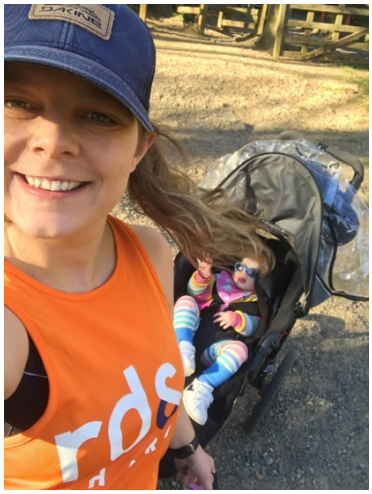
While also supporting with fundraising and donations for specific wards or departments, the RD&E Charity mostly focus their fundraising on our two appeals:

- Our Starfish appealis raising money to create a dedicated warm, bright and engaging space for the children, young people and families who use our children's services and outpatient waiting areas.
- The #HelpUsHelpYou appeal was launched to support RD&E staff during the coronavirus pandemic. The fund helps us to support the physical and mental wellbeing of our staff.

Fundraising for these projects enables us to benefit large numbers of patients and staff to ensure we can provide those extra things that make the difference.

Fundraising activities

Our supporters have been busy fundraising for us over the last year – here are just a few of the incredible challenges that have been completed for the RD&E Charity.



Exeter mum runs 117 miles across Devon for RD&E Charity

An Exeter mum ran 117 miles over five days from North to South Devon for the RD&E Charity's Starfish Appeal, as a way to thank the hospital for the support her family has received.

Sarah-Jayne said: "Our journey with the RD&E started when my daughter was just 10 weeks old. Every day, ambulance ride and surgery since, the staff at the RD&E have been exceptional. Our family's journey will be different but I feel assured and supported by the awesome teams that we have at the RD&E.

RD&E staff complete a 3000-mile row for the RD&E Charity

Charlie and Adam, two emergency medicine doctors from the RD&E, completed the Talisker Whiskey challenge, a 3000-mile row across the Atlantic, raising £25,000 for four charities, including the RD&E Charity.

Rowing from La Gomera to Antigua, the couple completed the challenge in an incredible 51 days, 3 hours and 48 minutes.

Pair cycle the 443 mile perimeter of Devon to raise money for the RD&E Charity

Two men from Devon completed an extreme challenge of cycling the perimeter of Devon today – an incredible distance of 433 miles –to raise money for the RD&E Charity's Starfish Appeal. The pair cycled non-stop for 48 hours around the perimeter of Devon over challenging terrain and with an incline of 46,000ft – the equivalent of 9 miles up.

Harry's story

Harry was born with a chromosome deletion in 2014. This means that he has a developmental delay, which means lots of outpatient appointments and frequent infections which often result in hospital stays on Bramble Ward.

Harry's mum, Louise, said: "When Harry was five weeks old, we went into the RD&E and we were told about his diagnosis. I remember this day so well as my husband and I couldn't believe what they were telling us and how this would affect our family life as we already had a toddler.

"Six years on and the bramble family at the R&DE has become a second home to us. The care received, not just medically but personally, to Harry and to us as his family has been outstanding. It has made our journey a lot easier.

"I know a lot of people think of a hospital as a scary or sad place but Harry, who is a frequent flyer of Bramble Ward, never once gets upset when we arrive at the RD&E or at the doors of the Bramble Ward because of how welcoming everybody is.

"We are forever grateful for all the staff on Bramble; this journey would have been even more difficult without you there holding our hands."

The RD&E Charity is able to support local patients and staff because of the generosity of local supporters and volunteers. We continue to look for new and exciting ways to fundraise and always welcome those who would like to get involved and make a difference to their local NHS. Further information on our charity can be found on https://www.rdehospital.nhs.uk/rd-e-charity/ or on our social media pages.

Our strategy

In 2021 the Board started developing a new corporate strategy scheduled to launch in 2022/23 alongside the launch of the new Trust: the Royal Devon University Healthcare NHS Foundation Trust. In the meantime, it is important to note that the RD&E's existing strategy continued to provide the foundations for the Trust's approach, retaining the existing strategic intent:

"We will be a leader in transforming the health and care system, working in partnership to connect people, services, communities and voluntary groups to meet the needs of the communities we serve. In doing so, we will continue to provide safe, high quality, seamless services delivered with courtesy and respect."

Our values of fairness, honesty, openness & integrity, respect & dignity, and inclusion and collaboration have set the parameters for what is important and how we work.. Our strategy underlines that our values apply to all of us equally and underpin everything we do as we work together to provide care for our communities.

Our corporate objectives have remained the same throughout the past year, which is to:

LISTEN to people and continually improve what we do. We will do this by building on our track record of providing safe, high quality services delivered with courtesy and respect.

CONNECT people, communities and services so that we can work together to improve health and wellbeing for everyone. We will do this by focusing on wellness, prevention and ill-health management, seeing patients as people, and empowering them to be in control of their own care.

INNOVATE so we can continue to grow our world-class specialisms, working with partners and our patients to push forward the best medical research

The Trust's corporate strategy was set four years ago and, while many of the structural issues the strategy sought to address remain, the external context has changed considerably.

During the last two years we have operated within the context of an unparalleled global pandemic. Inevitably, the pandemic has fundamentally changed many of the assumptions that underpinned the existing strategy and has highlighted issues that were perhaps not so clearly in our line of sight. Now, as we begin to emerge from the pandemic, its impact is being felt as we reduce the significant backlog of patients on our waiting lists. The pandemic has also exposed existing structural health inequalities that exist and have been worsened as a result of COVID-19. After two years, it is also clear that responding to the pandemic has taken its toll on our workforce who will need vital support to deal with the toll the pandemic has had on their health and wellbeing – especially frontline staff who have faced traumatic situations on a regular basis. Supporting all NHS staff to ensure they are physically and mentally well is vital to bringing down waiting lists and ensuring the highest standards of care.

At the same time, the response to the pandemic by the NHS, including the RD&E, was extraordinary and demonstrated that rapid change is possible and that working differently and in a more agile way provides an opportunity to tackle some of the challenges that have beset the NHS for many years. We acted swiftly to bolster our emergency preparedness and resilience and rose to the challenge with innovation, energy, and kindness. Whether it was the initial rapid response to the pandemic, the roll out of vaccines ensuring that all parts of society benefited or the use of digital technologies, the lesson is that, when needed, the NHS can embark on rapid change to meet pressing goals. The challenge to policy makers and senior leaders within the NHS is to agree a consensus about the best practices that emerged from the COVID-19 response and then deliver a strategy designed to make them a permanent feature of a new NHS model, building on the accomplishments made during this period.

The policy shift in the NHS towards ever greater integration of health and social care, the move from competition towards whole system cooperation, the focus on population health management and the use of joined up digital technologies and artificial intelligence, underline the way the context has changed rapidly in the last 4 years. These changes, alongside an NHS focus on recovering from the pandemic, demonstrate the need for the Trust to refresh and renew its strategy.

The other significant development that has impacted on the organisation over the last four years – and which was not considered in detail at the time – was the development of the enhanced collaboration with Northern Devon Healthcare NHS Trust, the ensuing Collaborative Agreement in 2018, and, over the last 2 years, the move to full integration in becoming a single organisation. The rationale for

coming together as one organisation to confront the challenges we both face, is documented elsewhere in the Annual Report. Since the Collaborative Agreement was agreed, good progress was made on ensuring there were sufficient numbers of staff responding to the global pandemic and within recovering and transforming services. Building on these foundations, the move to a unified organisation will place it in a stronger position to offer high quality, resilient services to the people of Devon, served by an aligned Trust no matter where they live.

The Trust has continued to develop its relationship with Torbay and South Devon Healthcare Trust (TSDFT) in the form of a Strategic Alliance which aims to enhance collaboration to secure sustainable, high-quality patient care for our populations into the future. TSDFT, RD&E and NDHT have been working together informally for some time as part of the SEND (Southern, Eastern, Northern Devon) acute network. We have strengthened our collaboration over the past 12 months as we have responded to the COVID-19 pandemic and worked to recover elective care. This approach aligns with the direction of government policy which promotes new, collaborative approaches between providers to delivering healthcare.

Over the last year, the Boards of both the RD&E and NDHT have been developing a new corporate strategy for the integrated organisation. The new strategy has been developed on the basis of the broader context that has emerged over the last few years and seeks draw on the strengths of both organisations. The new strategy is to be launched within the first quarter of 2022/23.

Developing our new strategy

In developing the new strategy, the Boards were keen to ensure that it was real and meaningful to our staff, reflected what was important to our patients, and was aligned to the plans and aspirations of our partners. To enable this, we carried out a widespread engagement campaign over several months so we could co-create our strategy with our staff and stakeholders to ensure it would make a real difference to the lives of people within the Devon communities that we serve.

Phase 1: Shaping our strategy

We held conversations with the Board and our Governors to ask what our common purpose should be, what we needed to change by 2027, and what behaviours we would need to demonstrate to achieve this. We also looked at a range of evidence including CQC reports, patient feedback, staff survey feedback and the nominations in our awards schemes.

Phase 2: Learning from COVID-19

When the COVID-19 pandemic hit us, we had to very quickly adapt and transform our ways of working so that we could continue to provide our services in a safe way. We decided to spend some time evaluating these changes and asking our staff and service users what their experience of these changes had been. This helped inform how recovery from COVID-19 impacts our future strategy.

Phase 3: Piloting our strategy

We finished our engagement by testing our strategy to check we were focusing on what was important. An online survey was sent out to all staff alongside running feedback discussions at existing staff forums and smaller open staff conversations. The key questions that were asked:

- What their initial thoughts were on the proposed new mission and objectives
- If they thought anything was missing
- What they would most like our new Trust to achieve
- Which values and behaviours were most important to them

We had so much insightful feedback, and were able to hear from multiple staff groups including staff side, staff group representatives, managers-all from a variety of different departments.

Key issues and risks

Operational

The operational planning process is undertaken annually, in order to plan the allocation of resources and support the delivery of key organisational targets. The planning process considers organisational circumstances known or reasonably predicted at the start of the year, however there remains risks to the delivery of key performance indicators, principally due to changes which happen throughout the year. These include but are not limited to:

- The impact of COVID-19, changes to guidance, and how behaviours impact the disease prevalence and demand for health services
- Changes to service provision at local acute Trusts which could result in increased demand on clinical services
- Unanticipated increases in General Practice or other referrals, particularly in cancer specialties requiring urgent 2-week outpatient appointments and subsequent diagnostics
- Changes in the urgent care landscape, such as the provision of 111 services, Minor Injury Units (MIUY), Walk in Centres (WIC), access to primary care and support for patients with urgent mental health issues
- Severe adverse weather affecting capacity
- Major infection control outbreaks, such as the high levels of flu experienced in 2014/15 and 2017/18
- Unplanned workforce availability such as the junior doctors' industrial action during 2014/15 and 2015/16. In the event of events such as those listed above, further discussions with commissioners, providers and regulators will take place to minimise the risk to performance
- Workforce fragility arising from extended pandemic response period.

Quality

Operational pressures secondary to our pandemic response, continued financial constraints, and the delivery of Cost Improvement Programmes (CIP) have the potential to impact the quality of our services. Mitigation of these risks centre on the robust quality assurance framework which is in place. Assurance is provided through mechanisms including the Integrated Performance Report, the Performance Assurance Framework and Internal Audit Reports. Together, these approaches incorporate a balance of hard, empiric data and soft intelligence which alerts relevant levels of clinicians and managers throughout the Trust to any deterioration in quality.

Finance

The continued presence of COVID throughout 2021 and 2022 and the threat of further waves represented a significant financial and operational risk to the Trust. The increase in infections in the community results in an increase in staff sickness, therefore resulting in an increase in bank and agency usage to ensure staffing levels are maintained.

In addition, high COVID rates led to increased hospitalisations which heightened the operational challenges within the Trust, resulting in further use of escalation beds requiring additional staffing and driving cost growth.

As we recover from COVID, the impact of future waves of infection as well as urgent care pressures impacts on the Trust's capacity to continue with high levels of elective care, with the risk of prolonged periods of elective cancellations. Under the elective recovery fund guidance this has an impact financially due to the claw back of income on any non-achievement of 104% thresholds of 2019/20 activity baselines.

There is also the national issue of 'missing demand' as elective referrals have not yet recovered across the board to pre-pandemic levels. This is likely to lead to an increase in demand in the future which will be difficult to deliver within current capacity as waiting list recovery is already challenging, but the acuity of presentation also increases, driving up the time patients are in our care and therefore the cost of treatment.

The economic environment also poses a significant financial risk to the Trust. The rising costs of inflation above funded levels, in particular energy prices, will see pressure placed on non-pay budgets. In addition, the impact of the rising cost of living on lower paid staff risks a recruitment and retention deterioration due to more lucrative roles being available outside of the NHS, further driving up cost in temporary workforce.

Finally, the changing financial guidance has created a financial risk due to the level of uncertainty on future longer-term planning. Short time frame changes in elective recovery guidance in particular thresholds to reach and value of income received changes the financial evaluation of decisions made. The Trust welcomes the expected stability in the finance regime going forward to provide a greater level of certainty in planning.

Going concern statement

After making enquiries, the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval of the financial statements and fulfil any liabilities as they fall due. The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements.

On this basis, the Trust has adopted the going concern basis for preparing the accounts.

KPMG have concluded that it is appropriate to prepare the financial statements on a going concern basis.

For further details, please see Note 1 to the Accounts on page 13.

PERFORMANCE REPORT: ANALYSIS

Performance management and assurance

The Trust Performance Assurance Framework (PAF) enables assurance to be provided that performance, including safety and quality indicators, is effectively monitored and reported, thereby supporting managers and clinicians to deliver the required targets. A key tenet of the Trust's Performance Framework is Monthly PAF meetings, chaired by the Director of Operations, with support from the Director of Nursing, Medical Director, Director of Operational Finance, and Head of HR Services, which take place with each of the four Clinical Divisions. At the meetings, divisional and speciality level positions are reviewed, covering a detailed set of indicators across safety and quality, performance, operational efficiency, workforce, finance and a wide array of supplementary information.

The reports prepared for the meeting also support the Clinical Divisions to undertake their own assessments of performance, as well as providing an outline of actions to address any key issues. The actions identified by the Divisions are tested and challenged in the meetings. During 2021/22 the routine schedule of PAF meetings has been interrupted due to the ongoing operational demands of the pandemic. The PAF meetings when held, have focused upon the actions being taken, and further support required, to achieve the following objectives:

- support the ongoing restoration of elective care service delivery,
- the clinically led prioritisation of elective care delivery including understanding of harm impacts arising from extended waits
- optimisation of clinical resource usage to drive maximum benefit for patients.

At the heart of the Trust's PAF is the alignment of monitoring and performance from service line and ward level through to Board. The monthly Integrated Performance Report to Board includes a wide range of national and local performance indicators grouped under the following themes:

- quality and safety
- activity & flow
- operational performance
- patient experience
- our people
- finance.

These are accompanied by narrative detailing the contributory issues, the actions planned to restore performance, the timeframes in which the actions are to be undertaken, and identification of any key risks. The integration of these indications within a single report provides an opportunity for triangulation of indicators and themes that is made explicit within the accompanying narrative and overview to the report. During 2021/22, additional indicators relating to the delivery of services in response to the COVID pandemic have been incorporated into the Integrated Performance Report, alongside the established indicator set.

Overview of performance 2021/22

2021/22 was a challenging year for the achievement of performance targets at the RD&E, as the Trust sought to progress the delivery of elective services as well as respond to the challenges of further waves of the COVID-19 pandemic.

The pattern of needing to flex and balance COVID and non-COVID service delivery through successive waves of increased COVID prevalence and patient hospitalisations continued to characterise 2021/22 in a similar manner to 2020/21. This has taken place against a local, as well as national, backdrop of increasing elective care backlog both in terms of volumes of patients as well as length of wait, with routinely referred patients experiencing extended waits for assessment and treatment. At the end of the financial year over 5,700 patients had been waiting longer than 52 weeks for treatment (equivalent to 1 in 11 of those on the Trust's waiting list), of whom over 650 had been waiting for longer than two years.

Coordination of the Trust's response to the pandemic has continued to take place through its Incident Management Framework, including Strategic Command, which has been in place throughout 2021/22.

As outlined below, 2021/22 has been a further year of considerable performance challenge. In keeping with other NHS providers, it has been necessary that available NHS capacity has continued to be prioritised for delivery of emergency care, including to those with COVID-19, whilst maximising opportunities for delivery of elective healthcare services to those patients for whom treatment had needed to be paused or deferred, and to those patients who had refrained from coming forward to seek treatment during the pandemic. The need for social distancing and infection prevention and control requirements to remain in place throughout the pandemic has resulted in a continued reduction in core hospital capacity. The Trust successfully bid for Elective Recovery Fund, and Targeted Investment Fund monies in 2021/22 which has facilitated additional short-term elective capacity, and the delivery of an increased range of services from a wider range of locations.

Indicator	Measure	Standard / target	2020/21	2021/22
18-weeks RTT	% admission – incomplete pathways	92%	52.2% (March 2021)	49.6% (March 2022)
	Total number of open pathways	30,251 (2018/19) 34,293 (2019/20)	54,047 (March 2021)	63,307 (March 2022)
	Volume of patients waiting longer than 104 weeks on an incomplete pathway			672 (March 2022)
Cancer Access	Urgent referrals seen within 2 weeks – all cases	93%	73.9% (span of year to March 2021)	68.6% (span of year to March 2022)
	Breast cancer symptomatic referrals seen within 2 weeks	93%	25.2% (span of year to March 2021)	17.7% (span of year to March 2022)
	Cancer treatment started within one month of diagnosis	96%	96.1% (span of year to March 2021)	93.6% (span of year to March 2022)
	Cancer treatments started within 2 months of urgent GP referral	85%	73.0% (span of year to March 2021)	68.1% (span of year to March 2022)
Cancer standards	Diagnosis within 28 Day of Referral	75%	78.81% (span of year to March 2021)	83.0% (span of year to March 2022)
Waiting Times	A&E maximum waiting times of 4 hours (Eastern Devon)	95%	81.1% (March 2021)	72.6% (March 2022)
Ambulance Handovers	Volume of Ambulance Handover Delays over 60 minutes	0	0 (March 2021)	24 (March 2022)
Discharge performance	Volume of (green) Medically Fit Patients on Transfer List		60 (March 2021)	83 (March 2022)

Delivery of the 4-hour A&E target has been increasingly challenged in 2021/22 as a result of a resumption of pre-pandemic levels of demand, complexities in patient flow, combined with workforce shortfalls and continuing impacts arising from COVID related infection prevention and control requirements. However RDE continues to deliver minimal ambulance handover delays which is a key safety measure. A system coordinated taskforce incorporating senior clinical and operational representation from across the Trust, and from health and care system partners, was established in Autumn 2021 to identify and progress actions to overcome barriers to improve urgent care performance and flow, and to coordinate system responses at times of peak challenge. Alongside this, the Trust's Board of Directors agreed to a significant investment in the Trust's Urgent and Emergency Care service delivery, in recognition of the changing patterns of emergency demand and care, so as to support increased capacity and flow.

In 2021/22 the volumes of elective referrals have risen to be broadly comparable to pre-pandemic levels, bringing a further challenge alongside the backlog of patients who were unable to be seen in the first 12 months of the pandemic. The reductions in available physical capacity as a result of requirements for social distancing and enhanced infection prevention and control provision, have required innovative flexing of both the estate and the workforce to support new

patterns of service provision. This has included services being relocated to community hospitals and the re-provision of the Nightingale (a Trust hosted System Asset). There has been an increased use of virtual outpatient clinics, and patient initiated follow-up care.

The Trust starts the 2022/23 financial year with a significant performance challenge but has developed a programme with projected improvements across all areas. The driving of our flow programme in the early part of the year has allowed us, even in the face of further escalation as the financial year ended, to re-establish elective operating in all of our theatres and also to staff the Nightingale. This achievement gives us a clear upward direction of travel going into the new financial year and a strong sense of purpose that we can use the new resources available to rebalance our services following the most recent COVID-19 waves.

Financial performance

The trend on the RD&E's financial performance has been impacted by changes in the financial regime over time due to the COVID-19 pandemic. A breakeven regime was established for the 2020/21 financial year resulting in additional non-recurrent top-up income and additional allocation to support the financial impact of responding to COVID-19. The funding regime continued into 2021/22 with the year split into two half year planning periods (H1 and H2). The non-recurrent funding has compensated for the underlying deterioration in the financial position across the financial years. Due to a building cost base however as a result of a strategic investment in digital capability, the response to operational pressures and the inability to deliver the expected level of cost improvement due to the environmental circumstances and pressures, this will not continue into 2022/23 and the Trust is planning for a deficit.

Contracting during the COVID period has continued to be through a block contract basis from our main commissioners, Devon CCG and Specialised Commissioning. The exception to this has been the introduction of an incentivised elective recovery scheme providing a variable element to the contract allocated through agreement with Devon System partners. The ability to earn against the ERF is determined against a system level of activity performance.

During 2021/22 the operational pressures led to a number of workforce challenges, and recruitment and retention across the whole of the NHS worsened. The Trust benefited from savings on substantive staffing but experienced an increase in agency spend as a result, along with the need to cover increasing levels of staff sickness. In total £10.6m was spent on agency against an agency cap set by NHSEI of £8.7m.

Capital expenditure for the year was £55.9m, £28.4m higher than planned due to a number of national schemes being funded partway through the year not recognised at planning stage. This included continued investment in the Nightingale Hospital Exeter, for which the RDE is host, to adapt the facility from a COVID bedded unit to a day theatres and outpatient facility to support elective recovery for the Devon system.

Capital expenditure by scheme in 2021/22 is set out below:

- Nightingale Hospital Exeter reconfiguration £16.2m
- Emergency Department reconfiguration £11.2m
- Preparation for Surgery £3.8m
- Estates Infrastructure £3.9m
- Linear Accelerator replacement £2.2m
- Other schemes and equipment replacement £18.6m

Looking forward to the 2022/23 financial year there are further changes in the financial regime. A further savings target is being applied across systems to bring income levels back towards system allocations. In addition, there is a reduction in the level of additional COVID income being received as we plan to return to a business as usual state. The income changes and continued operational pressures, along with elective recovery, results in a challenging financial environment ahead. The financial plans for the Trust show an increased deficit position. To reach this deficit position the Trust will need to deliver savings of £24m through a combination of cash releasing savings, productivity gains and COVID cost-reduction.

The table below highlights the deficit reported in the Annual Accounts, the surplus / deficit for the purposes of NHSEI reporting (excluding impairments and donations) and the underlying deficit on removal of non-recurrent benefits.

	2022/23 Plan	2021/22	2020/21
Surplus (Deficit)	-29.4	-4.4	-16.1
Less non-recurring impairments / donations	0.4	10.7	16.1
Surplus / (Deficit) for NHSEI reporting	-29.0	6.3	0.0
Less other non-recurrent changes	-15.2	-64.5	-41.7
Underlying Deficit*	-44.2	-58.2	-41.7

*2022/23 plan underlying position includes top-up income not included in 2021/22 or 2020/21

NB changes in finance regimes over the reporting period make comparisons of underlying issues difficult.

The Trust merged with NDHT on 1 April 2022 and continued to collaborate across both Trusts during the financial year in preparation. As a single entity with the merger of NDHT the deficit will increase further as both organisations have underlying deficit issues. However, through combining leadership and resources it is believed the new combined entity will be in a much stronger position to face the financial challenges ahead and develop a longer-term financial strategy for both sites that stabilises the financial position and makes inroads into financial recovery.

Both Trusts also continue to work closely with the Devon System on the overall financial recovery for the system. The predicted level of deficit in 2022/23 across the system is significant and with a distance from target income for the system the challenge to return to breakeven can only be met through longer term transformational change. The System is focusing on the key priorities of:

- Urgent and Emergency Care (UEC) resilience – including social care, mental health, community pathways and primary care access. Includes engagement with the public regarding UEC choices
- Planned Care – reduction in long waiters, through delivery of accelerator and Targeted Investment Funding (TIF) schemes
- Diagnostics-both networks and community hubs to improve access for our populations
- Children and young people – across a broad spectrum, including mental health, transition to adulthood and pathways
- Digital –ensuring that we continue to get the benefits of digital working. Need to link work on pathways. Building on the success of Your Shared Care Record

Our People

In recent years there has been a considerable national focus on our people, with the launch of the NHS People Plan, NHS People Promise, NHS Health & Wellbeing Framework and the NHS HR and OD Programme. The key objectives in these national programmes align strongly with the Trusts', and although many of the outcomes from these will be driven at a national or regional level, the Trust has made a great deal of progress locally. Some of the Trust's key achievements in 2021/22 have been detailed below:

Senior people function restructure

In 2021/22 a new joint people function leadership structure was delivered to provide greater levels of collaboration between RD&E and NDHT ahead of the proposed integration, ensuring that best practice is shared across the Trusts and to reduce duplication of effort. The new structure addressed issues of under-resourcing in some key areas as well as introducing centres of expertise in Wellbeing, Inclusion & Employee Experience and People Development. Additionally, the new structure includes resource dedicated to Strategic Workforce Planning, a vital area after the integration of both Trusts.

Health and wellbeing

2021/22 saw the launch of a unified Employee Assistance Programme platform (Vivup) across both Trusts. This platform incorporates a range of employee benefits and wellbeing resources, designed to improve the physical, financial and mental wellbeing of our people. Additionally, guidance on how employees can build wellbeing into everyday working has been developed and communicated to managers to help them to support their staff as well as themselves. The Vivup platform also provides reward offerings to staff such as car and bikes schemes, white goods and travel. Ontop of our in house services, we have worked with the system and provided additional psychological support for staff through Talkworks (provided by DPT) and the Devon Wellbeing Hub to ensure good support for all health and social care workers in the system

Over the last year, the Trust have facilitated a significant increase in remote working in response to COVID-19; however, there is work ongoing to understand how agile working could become part of the normal offer for staff in the future. Additionally, a team at the RD&E have partaken in the 'NHS Flex for the Future' programme looking at flexible working within the NHS and planning work is now underway following a series of workshops to understand how these tools can be utilised to improve the flexible working offer for our people.

A number of dedicated groups have been set up in order to ensure that wellbeing initiatives of varying types can be implemented for our people. This includes a Joint Wellbeing Group covering both the RD&E and NDHT, a Morale Programme Group to monitor specific initiatives to support staff wellbeing and improved morale and a dedicated staff space group to ensure that our people have high quality,

accessible welfare facilities. This year a number of rest spaces and staff kitchens have already been refurbished, providing staff with much needed space to take a break.

Diversity and inclusion

Diversity and inclusion are of paramount importance in the Trust and are essential to ensuring that all of our people belong. In addition to the people function leadership restructure, two new posts of Inclusion Lead, and Diversity & Inclusion Analyst, have been added to the structure to support this really important work.

A lot has happened in the past year, including the introduction of specialist external as well as internal inclusion training for staff, re-invigoration of the Trust Diversity & Inclusion Steering Group, chaired by the Trust CEO and an increase in Inclusion Champion numbers. Additionally, three staff networks have now been fully established with proposals underway for other additional networks in the future.

Inclusion action plans have also been developed, focussing on recruitment and people development. Coaching and interview preparation sessions are now in place and are aimed at those who may be more disadvantaged, supporting them to progress within the Trust.

Resourcing

Recruitment and retention of staff has never been so vital a challenge for the NHS and other sectors alike, and as such it is essential that the Trust is competitive and can attract and retain the best possible talent. In the past year a specialist Executive and Specialist Recruitment team was established in order to reduce reliance on search firms for very senior and hard to recruit posts. This team has been hugely successful, securing medical, specialist and hard to recruit candidates worldwide. The team have also been working with a number of companies and organisations, both within and outside of the NHS, as well as utilising social media to increase the Trusts visibility and ability to compete with other sectors. The Trust have been hosting webinars and online events to target people outside of Health & Social Care to apply for roles such as HCA positions, as well as starting to return to face to face recruitment events where appropriate. Discovering hidden careers in the NHS is also being scoped to draw attention to those roles not necessarily associated with the NHS, such as estates and facilities staff, research and corporate services.

Sustainability

In January 2020, the campaign for a Greener NHS was launched to mobilise more than 1.3 million staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero by 2040[1].

To support this, the RD&E and NDHT have developed a Green Plan, which sets out how both Trusts plan to go about achieving their long-term sustainability goals and 'Net Zero' targets. The Green Plan will act as a sustainability guide to the design and implementation of our future services and will act as a strong foundation to ensure that the environmental ambitions are embedded into everything we do.

The Green Plan, which was signed off by the RD&E and NDHT's Board at the end of January, must now be delivered across both Trusts. This plan sets out the communication and engagement objectives, approach, key messages, timeline for delivery, and outputs required to support the plan's delivery. The Green Plan delivery is being led by the Deputy Chief Executive, supported by the Director of Business, Innovation and Sustainability.

Sustainability initiatives will be driven by their operational departments and will complement this plan through alignment of their key messages, objectives and approach.

This plan was been developed at a time where the RD&E and NDHT were working closely together as part of their proposed integration. As such, all objectives, communications and engagement activity will be delivered across the newly formed Trust in an aligned way that draws on the strengths of both organisations.

The sustainability section of the Annual Report will detail progress against the Green Plan, and at a minimum, include the mandatory reporting requirements as required by NHSI/E's Greener NHS team. The scope of this report is to capture performance over the last year of the RD&E's activities.

Social, community, anti-bribery and human rights issues

We are committed to ensuring that services are accessible, appropriate and sensitive to the needs of the whole community, with a workforce representative at all levels of the population it serves.

The Trust is working hard to deliver services to its patients and staff, which reflect equality, diversity and inclusion in all areas and respect of human rights, in

accordance with the requirements of the Equality Act 2010, the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme (WDES) and Gender Pay Gap Reporting. Action plans to identify and address issues related to WRES, WDES and gender pay reporting are monitored by the Board and the Inclusion Steering Group chaired by the Chief Executive Officer. We are committed to ensuring the advancement of equality of opportunity between different groups, whether they are people who work for us or the patients and communities we serve. As a public body we believe it is our duty to work towards eliminating discrimination and help foster positive relations between the different groups that make up society.

Our work with the Eastern Local Care Partnership, with our health and social care partners and the voluntary, community and social enterprise sector seeks to address heath inequalities and is carried out in accordance with the Equality Act 2010."

Throughout 2021/22, the Board has remained committed to maintaining an honest and open atmosphere, ensuring that all concerns involving potential fraud have been identified and investigated in line with the expectations of the NHS Counter Fraud Authority. In any such cases appropriate civil, disciplinary and/or criminal sanctions have been applied, where guilt has been proven to the required standard.

The Trust engages ASW Assurance to provide a suitably qualified and nominated Local Counter Fraud Specialist (LCFS) to support its work in this area. This has helped to create an anti-fraud culture, including a new Counter Fraud Champion role held by the Operational Director of Finance, which has enabled deterrence and prevention measures to be embedded in the organisation.

The Trust's Audit Committee agrees the annual work plan for the LCFS and receives routine reports on progress against its delivery. The Committee has agreed the Trust's policy for dealing with suspected fraud, bribery and corruption. The Trust submits an annual self-assessment about its counter fraud arrangements and work against the Government Functional Standard GovS 013: Counter Fraud to the NHS Counter Fraud Authority.

Important events

RD&E and NDHT merger: On Friday 1 April 2022, the RD&E and NDHT formally merged to become the Royal Devon University Healthcare NHS Foundation Trust. Read more on page 13.

By combining forces, the new organisation seeks to reap the benefits of:

- operating at a larger scale to overcome the issues faced in delivering healthcare in rural settings
- working collaboratively both within the merged Trust but also with our partners and communities
- seeking to ensure that people and communities have access to high quality healthcare wherever they live
- Improving the quality of, and access to, care as a result of more resilient services
- stablishing digital-first services to help overcome the issues of rurality and access
- better partnership working, enabling the organisation to help address the wider determinants of health with, and alongside, its statutory and voluntary sector partners
- increased research capability relevant to the Devon population and its demography
- expanding the Foundation Trust model of governor and member representation to develop more accountability to a broader population
- giving confidence to the Northern Devon community on the local access to acute and urgent care services in Northern Devon
- ensuring greater efficiency and releasing resources for reinvestment in clinical services
- developing a more resilient workforce that is motivated, engaged and valued

While the name of the overall Trust has changed, North Devon District Hospital, the Royal Devon and Exeter Hospital (Wonford and Heavitree) and the Trust's community services – including community hospitals – will continue to be known by their existing names.

New Chair: Dame Shan Morgan took up her role as Chair of the Royal Devon University Healthcare NHS Foundation on 1 April 2022.

Dame Shan will take on the role for an initial term of office of three years and succeeds Chairman James Brent, who came to the end of his term of office on 31 March 2022. Dame Shan was appointed following a robust recruitment process, with an appointment panel made up of stakeholders representing both organisations.

Dame Shan has a wealth of experience from her career working in a variety of roles for the Foreign Office. She has held roles as HM Ambassador to Argentina and Paraguay, and has represented the UK in the European Union. In her previous role, Dame Shan was head of the Civil Service of the Welsh Government and led over 5,500 staff, with responsibility for a budget of £17billion.

Dame Shan was appointed Companion of the Order of St Michael and St George (CMG) in the 2012 New Year Honours List, and Dame Commander of the Order of St Michael and St George (DCMG) in the 2017 Birthday Honours.

Equality performance

Equality of service delivery

The Trust is committed to working to become a national exemplar for diversity and inclusion. We aim to create a positive sense of belonging for everyone, regardless of their background or identity, to value visible and invisible differences.

For us, inclusion is about positively striving to meet the needs of different people and creating environments where everyone feels respected and able to achieve their full potential. However, we know that there is a lot to learn and do, and we are committed to doing so because it's the right thing to do for both staff and the people we care for. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010, regardless of race or ethnicity, age, disability, nationality, gender, gender reassignment, sexual orientation, religion or belief, marriage and civil partnerships.

Inclusion is central to our mission

The RD&E corporate strategy sets out a vision to 'deliver safe, high quality, seamless services delivered with courtesy and respect'. The strategy emphasises that the Trust is a values-driven organisation and inclusion is central to achieving its mission.

Our Board of Directors has increasingly understood that inclusion is fundamental to the approach the organisation takes to organisational development, culture change, service improvement, and public and patient engagement. Moreover, while the focus on protected characteristics in this field must remain central to our work, there is a keen sense that there are other barriers that reduce equality of access, or which lead to discrimination and our work must reflect this broader understanding.

We aim to:

- Improve everyone's – patients, carers, staff – experience of the RD&E in line with our values and inclusion ambition;
- Ensure our services are delivered in a way that is demonstrably inclusive and that enables equality of access for all;
- Create an environment where our staff have an ongoing sense of belonging and everyone is able to flourish and progress equally.

The Trust has appointed an Inclusion Lead to provide strategic oversight of the inclusion agenda, whilst also being in the process of appointing an Associate Director of Wellbeing, Inclusion and Employee Experience, and a Diversity and Inclusion Data Analyst to further support our ambition.

We have refreshed our approach to inclusion to ensure that it:

- Fully reflects the central importance of inclusion to our corporate strategy;
- Builds on the steer provided by the Board – who are vital to setting the tone and leadership on inclusion – drawing upon the experience and insight of our staff and the communities we serve, i.e. developed in a way that is inclusive;
- Takes into account the need to build a social movement for change within the organisation- focussing on attitudinal shifts and changing ways of working, to fully embrace diversity and inclusion.
- The Trust aims to ensure that all of its healthcare services are accessible and inclusive to everyone in line with our legal duties under the Equality Act 2010.
- Over the last two years we have initiated two projects to promote improved access for specific patients' groups that have expressed the view that they face barriers in accessing healthcare services. We have held workshops with people who are deaf or hard of hearing to better understand and respond to the issues they have raised with us. As a result of this work, we have put in place improved access to British Sign Language interpreters, to mobile hearing loops and we have started to develop improved staff awareness of deaf and hearing loss issues.

- We have, and continue to, work with a group of people with learning disabilities to ensure that we enable improved access to healthcare services. This has resulted in improved understanding about the issues faced by the learning disabled community and the introduction of improved communication materials.
- We expect staff to challenge any discriminatory or harassing behaviour, and to report them through procedures such as grievance, disciplinary, whistle blowing or incident reporting.
- We are also working hard to meet the requirements made on all NHS organisations of the accessibility information standard. In addition, we aim to make our website as easy to use and understand as possible. We want visitors with disabilities to have the same benefit from using our website as those who are able-bodied

Learning disability liaison

The Trust has a dedicated team of Learning Disability Liaison nurses. The team support people living with a learning disability, and those who care for them, to access our hospital services in a way that works for each individual. This includes supporting patients with a learning disability during their time in hospital and providing education, advice and support to our staff.

Access support card

The 'Access Support Card' is an initiative launched by the RD&E to assist patients and staff with improved communications. Any patient or carer with a communication difficulty or disability can have one. Patients simply show their bright yellow card to staff on arrival at the RD&E to indicate a need for extra support or assistance. Staff will then respond by putting in place the extra support necessary, as far as possible.

Support may include:

- enabling a patient to arrange future appointments before leaving the site
- providing information in a way that the patient can understand; for example, using interpretation or translation services, Braille, audio, large print, or an easy to read format
- arranging appropriate support for the patient to access their appointment, for example a hospital volunteer to assist
- ensuring, with patient consent, that any 'special requirements' are flagged on a person's clinical notes, so that staff can best support them

The Access Support Card includes a patient's NHS number and an emergency contact number.

The cards help reassure patients that we are prepared and can offer the support they need. The card may also help to promote independence for patients who otherwise may need someone to accompany them.

ACCOUNTABILITY REPORT

Enhanced quality governance reporting

Patient care

The Trust, as a public benefit corporation remains inextricably linked, through the Council of Governors, to our members. The demographic information we hold about our members suggests that there is a reasonable correlation with the demographics of the wider population. To this end we have sought to involve and engage our members to seek their views on strategic direction, on service improvements or changes, and on improving patient experience as a reasonable proxy for the population served by the Trust.

All Governors are involved with identifying yearly priorities with a quality perspective. The Governors and members contribute to the quality agenda in a variety of ways, although these have been somewhat reduced due to our ongoing pandemic response.

Performance against key healthcare targets

The Trust has continued to work towards delivering the key national health care targets relating to quality throughout 2021/22. In previous years the Trust had utilised a local quarterly report as part of its internally developed Ward to Board framework. As part of the Trust's review of quality systems the Integrated Performance Report was reviewed. This incorporated quality metrics from the Ward to Board Framework, increasing key aspects to monthly reporting. This aimed to increase Board oversight and assurance of key quality performance indicators.

Monitoring improvement in quality

The Trust adopts a balanced scorecard approach to monitoring quality, presented through the Board's Integrated Performance Report (IPR). The Governance Committee has a comprehensive oversight of the quality and safety of care, including all inpatient, outpatient areas and community services.

The Trust's Clinical Quality Assessment Tool (CQAT) forms part of the Patient Experience Framework, reporting into the Trust's Patient Experience Operational Group (PEOG). Key quality and safety indicators are reported and monitored through PEOG, and exceptions are reported to the Joint Patient Experience Committee.

A reduced schedule of Ward Accreditation Visits has been in place throughout 2021 – 2022, due to the ongoing operational pressures.

During this period the Trust has worked in Partnership with NDHT to develop a revised Joint Ward Accreditation Programme. This will be implemented in 2022 – 2023.

The Trust uses the Performance Assurance Framework (PAF) to provide assurance that performance, including quality and safety indicators, are effectively monitored and reported to support Divisional Managers to achieve and maintain the required Quality Standards.

Service improvements

South West Ambulatory Orthopaedic Centre (SWAOC)

SWAOC has been set up as a direct response in tackling the Elective waiting list backlog that has occurred as a result of COVID-19 pandemic.

The Unit is available to the hospitals within the South West with referrals from NDHT, RD&E, Torbay & South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP). We are also working with colleagues at Yeovil Hospital and Musgrove Park Hospital to explore taking accommodating Somerset patients.

The unit opened on the 14 March 2022 and in its first week provided joint replacement surgery to 10 patients from across the region. 100% of patients were discharged within one day of surgery, 50% of patients were discharged as day cases, and all the patients phoned the day after discharge were delighted with the care they received.

Learning from national best practice, and with a commitment to innovation, the orthopaedic unit is a test bed for clinical improvement and changes in clinical practice.

The unit is currently in its first phase of a test of change model, with innovations including:

- Day and very short stay arthroplasty pathways
- "Virtual" patient preparation material delivered using new IT solutions

- Wearable technology which records patients' post-operative progress
- Innovative IT solutions to optimise clinician working and communication, and patient access to healthcare

Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem)

The Trust is proud to be part of the PERIPrem project, and are especially proud that these evidence-based interventions have been incorporated into our normal care for Pre-term babies to ensure that we give the best possible care to our smallest patients. The regional lead for PERIPerm is based within the Trust.

The PERIPrem project is coordinated by the South West Academic Health Science Network, to improve outcomes for the most vulnerable babies who are born prematurely.

- Prematurity is a leading cause of neonatal death and long-term disability, so optimising the care for these babies can have huge benefits, not only for the babies and their families, but also for the wider health service
- The PERIPrem Bundle of perinatal interventions contributes to a reduction in brain injury and neonatal mortality

The Trust chose to focus on delayed cord clamping (or optimal cord management) and early breastmilk as the interventions where we felt we could make the most improvements to the care we give.

Feedback to the Trust from the PERIPERM project has been extremely positive:

"Extremely impressed with the RD&E – they have the perfect set of numbers. Not easily achieved. We are also extremely impressed with probiotics and hydrocortisone use. The RD&E have literally implemented two brand new pharmacological treatments in a year, with extremely high uptakes. This is virtually unheard of in clinical practice."

Relocation of Rheumatology Services

The Rheumatology Clinical Service and the multidisciplinary team has operated for several years from three different sites. The medical team have been located at Wonford Hospital where outpatient clinics have been based. The Specialist Nursing team have been based both at Wonford and Nightingale Hospital Exeter (NHE). The infusion service, which administers infusion treatments for Rheumatology patients, has been situated at Heavitree hospital, distant from the medical team.

This has impacted cohesive service delivery, communication within the team, multidisciplinary team working and the level of clinical supervision and support able to be provided to the nursing team.

In January 2022, the entire Rheumatology Service moved to its new location at NHE. The outpatient clinics, infusion service and the whole MDT are now located in a single purposely designed department. This has led to an improved service and environment for the patients and has also improved communication, clinical supervision and support, and team working for the Rheumatology staff.

Patient Surveys

Urgent and Emergency Care

The Urgent Care national survey is carried out every two years. The Trust offers both Emergency (Type 1) and Urgent (Type 3) Care:

- **Type 1** – (ED on RD&E site) A major, consultant-led A&E department with full resuscitation facilities operating 24 hours a day, seven days a week.
- **Type 3** – (Honiton MIU) Another type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients.

The Trust results were very positive, ranking 11 out of 66 Trusts for Type 1 Care and 4 out of 66 for Type 3 care. with 7 of the 41 questions relating to the patient's experience at the hospital being significantly better than the Picker average.

Trust services are ranked in the upper quartile, and performance remains either at or above the average scores throughout the Survey.

The results have been reviewed and an action plan developed for further improvement. The main areas of focus for the next year are:

- Improving waiting times, which links with the Trust-wide work on improving hospital flow.
- Focus on infection control precautions in a very busy clinical area
- Ongoing reconfiguration and building works in the department, as part of the broader Emergency Care Redesign.

Children and Young People

The 2020 Children and Young People's Patient Experience Survey was conducted by Picker on behalf of the Trust, with an overall positive score.

1,090 patients were invited to complete the survey, with 1,089 being eligible at the end of the survey. 31% (342) completed the survey, which exceeded the 24% average response rate to similar organisations.

The Trust scores highest in areas such as communication with families, management of pain and the impact that our staff themselves have on care.

In order to prioritise work in the next few months, areas rated as red have been reviewed in the first instance and an action plan created. The areas focus on environmental issues and facilities available to young people. The main areas identified for improvement were:

- Opportunities for play (play staff and stock of play provision)
- Quality of Wi-Fi
- Overnight Facilities for Parents
- Ability to prepare food

The action plan will be managed via the Paediatric Governance Group, with regular updates to the Specialist Services and Surgical Services Divisional Governance Groups.

Maternity Services

The National Survey was reinstated for 2021. Results from this survey are compared with both the previous National Survey in 2019, and the New Mother's Experience of Care survey in 2020.

This report also shows the Trust's results in comparison to the average of the 66 acute trusts that worked with Picker on this survey (the "Picker Average").

The overall results for the Trust maternity service are very positive. The Majority of results were equal to or above the survey average:

- Antenatal Care
  The Trust was rated equal to or above the Picker average for each category, including achieving 100% in one category:
  B14: "Spoken to in a way they could understand."
- Labour and Birth
  Of the 15 categories reported on, the Trust scored above or equal to average for all, including a score of 100% in two of the catagories:
  C16: "Found staff introduced themselves"
  C23: "Treated with respect and dignity"
- Postnatal Care
  The RD&E scored above average for six of the eight categories. Of the other two categories, the following was noted:
  D2: "Discharge Without Delay"
  D7: "Partner was able to stay with them as long as they wanted (in hospital after the birth)"
- Care at Home (after birth)
  The Trust scored above or equal to the survey average for 15 of 17 categories. One of these was 1% below average, which is not a significant finding. The remaining category was:
  F1 'Given a choice about where postnatal care would take place'

The Service has developed an action plan to address any areas for improvement identified through the Survey

National Inpatient Survey

The Trust received overall positive results from this survey. There were 43 questions relating to patient experience, and the Trust was rated significantly above the Picker Average for four of these items, and at average or above for an additional 38 questions.

The results were analysed by the Patient Experience Operational Group, which identified the following improvement areas:

- Always or sometimes enough nurses on duty
- Felt involved in decisions about discharge from hospital
- Staff did not contradict each other about care and treatment
- Told who to contact if worried after discharge

Progress will be monitored through the Patient Experience Operational Group

Learning from patient feedback

End of life (EOL) visitors' badges

Restrictions to visiting have been extremely challenging for our patients and their loved ones throughout our pandemic response.

In response to feedback from a relative regarding open visiting for EOL patients, the Lead Cancer Nurse requested that we create a card which can be personalised and provided to visitors to indicate their entitlement for open visiting.

The card was developed reflecting the trust's EOL butterfly and with prompts to document EOL visiting discussion and authorisation.

The card has been trialled on Yeo and Yarty wards.

In addition, there is also a visiting card and lanyard for visitors accompanying patients with additional support needs to Oncology Outpatients and Cherrybrook Ward, and a poster advising of the oncology and haematology visiting restrictions.

Improving access to essential blood testing

Blood testing is essential for the monitoring, treatment and diagnosis of rare diseases in children. The impact of COVID-19 restrictions had a significant negative impact on these services.

In response, the Department of Blood Sciences implemented a rapid improvement, creating a remote finger prick capillary blood collection service. The laboratory in Exeter adapted its popular direct-to-consumer offering with Monitor My Health. This made it possible for clinicians undertaking remote consultations to electronically order a blood collection kit. This is sent directly to the patient's home. Blood collected by a simple finger prick into microsample tubes is then sent by post back to the Trust's Blood Sciences Department. They are able to analyse the samples and transmit results directly back to the requesting clinician.

This innovative approach is attracting huge interest from many other clinical groups, facing similar barriers to a patient's access to blood test diagnostics, and earned the department a Health Service Journal award for "The Acute Sector Innovation of the Year".

Smiling faces

Many people are nervous attending hospital, and the requirements of COVID-19 restrictions reduced the reassurance from staff, as their faces were covered by PPE. Patients commented that not being able to see who was treating them increased their anxiety. While caring for COVID-19 patients, clinical staff wore full personal protective equipment from head to toe.

A simple initiative in response to this feedback was the introduction of smiling faces badges. These were introduced to help reduce the fear that patients may have felt with staff in the PPE masks.

Staff members were asked to provide a head/shoulders photograph of themselves smiling, which was then printed and laminated by the PALS team and a badge was made. The badges were then worn by the staff to enable patients to see their 'smiling' face. It was felt that if a patient could see a picture of the staff member smiling it would be less intimidating and help reduce the anxiety that patients may have felt with staff in the PPE masks.

Complaints Handling

The complaints and concerns performance for the period 1 April 2020 to 31 March 2021 shows an overall decrease of 39.6%% in the numbers received when compared to the same period for 2019/20 (1204). The Trust received 334 complaints and 491 concerns.

All complaints are required to be acknowledged within three working days in line with Trust policy and statutory legislation. During the year, 98% of complaints were acknowledged within this timeframe. This was an improvement on the previous year's performance.

During the same period 64% of complaints were responded to within the Trust target of 45 days. Delays in investigations are often due to complex issues, issues which span more than one division or third-party organisations' involvement. This is consistent with the previous year's performance.

All feedback from patients and their families is used to help us further improve our services. A detailed analysis of patient experience, including complaints, is presented on a quarterly basis to the Joint Patient Experience Committee. The Committee ensures that learning from complaints and Demonstrating Difference examples are shared.

The top themes for complaints (not including concerns) received by the RD&E are in line with the national themes, and are as detailed below:

Theme	No of Complaints	% of Total
Communication with Patient	73	21.5%
Values and Behaviours	37	10.91%
Patient Care	28	8.26%
Appointments	27	7.96%
Admissions and Discharges	23	6.78%

The Ockenden Report

The final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH) was published on 30 March 2022 following a five year review of maternity care at SaTH.

Since the publication of the first report from the inquiry in December 2020, the Board of Directors in both Public Board and in Board sub committees has received assurance regarding the Trust's delivery against the identified seven immediate and essential actions to improve quality and patient safety across maternity services nationally.

This has also included:

- The Board assurance process for providing a clear line of sight of maternity services has been reviewed and strengthened.
- A further review of the workforce establishment and skill mix was undertaken, and investment made to deliver on the consultant-led ward rounds & to meet the full midwife requirements of birth rate plus.
- Ockenden suggests multidisciplinary teams will work better together and there has been investment in training; and to further support multidisciplinary team working culture, a development programme for leaders in our Northern location was commissioned.

Stakeholder relations

Communicating with, involving, and including stakeholders' is the foundation of our approach.

Effective engagement relies on our commitment to listen and communicate openly and honestly with stakeholders. NHS Services are of particular importance and interest to most people – whether provided in the community or in hospital. By working with our stakeholders, our goal is to achieve improved mutual understanding and trust. We want to listen to the ideas of local people and understand them better to help us make improvements to the way we provide services. We aim to create a culture of partnership with patients, staff and the community, for patients to be involved in their care, for ongoing listening and learning, and for everyone to work together in the design and delivery of services for the continuous improvement of the healthcare services:

The RD&E works with a wide range of partners from the statutory and voluntary sectors:

- we have established good relations with our local MPs and politicians in local government
- we have, over the years, sought to foster positive relationships with primary care colleagues
- we work closely with the University of Exeter, particularly on the Joint Research Office (JRO), a leading centre for high quality research, development and innovation in the South West peninsula. The JRO works hand-in-hand with the RD&E Innovation Hub and the University of Exeter's Innovation Impact and Business department, to bring health innovations to life for patients and businesses.
- we work in close partnership with many voluntary, community and social enterprises (VCSE) to continually improve care and offer more integrated care

The development of the Integrated Care System Devon, in line with the vision set out in the NHS Long Term Plan, provides a key vehicle for developing the networks and relationships necessary to drive improvements in health and social care in Devon, address the wider determinants of health, and focus our resources in the areas where they are most needed.

Developing the Integrated Care System for Devon

Work has continued throughout the year to prepare for the transition to the new Integrated Care System (ICS) for Devon, which is now expected on 1 July 2022, to allow additional time for the Heath and Care Bill to progress through parliament.

ICSs will be led by an NHS Integrated Care Board (ICB); an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP); a statutory committee bringing together all system partners to produce a health and care strategy.

In November 2021, the ICS was delighted to announce the appointment of former GP and MP Dr Sarah Wollaston to the role of Chair of the ICS for Devon. Sarah, who took up the role in December 2021, brings a wealth of knowledge and experience to this vital role.

At the same time, Jane Milligan was formally appointed to the role of Chief Executive Officer for the new Integrated Care System for Devon (ICSD), when it officially comes into being. Jane joined the Devon system in April 2021, having previously worked in north east London.

Devon is in the process of appointing to both the ICB and ICP.

Under new structural arrangements relating to ICSs, clinical commissioning groups will be dissolved. CCG staff will transfer to the new organisation and work closely with the three local authorities, NHS trusts, general practice, community services, mental health services, and the voluntary and community sector to provide joined up care that improves the health of all residents.

Central to the success of the ICS for Devon will be collaboration and partnerships, with organisations seeking to build on the progress made in recent years and the close working forged during the pandemic. Recent examples of partnership working include provider organisations in Devon providing mutual aid throughout the pandemic as well as collaborating the re-purposing of the Nightingale Exeter Hospital to support the waiting time recovery plan. The monthly One Devon Bulletin also showcases successes and good practice in partnership working and collaboration across the system.

Devon had made good progress in starting to address longstanding financial challenges before the impact of the COVID-19 pandemic.. NHS England is now providing additional assistance to make the changes needed through a new Recovery Support Programme. The level of support provided by NHS England is rated from one to four, with four being the most intensive support. The Devon system is being provided with Level Four support and welcomes the assistance in addressing these historic challenges and issues.

System achievements

Throughout the last year staff and volunteers across Devon have continued to rise to the challenge of rolling out the fastest vaccination programme in British history. More than 2.7 million COVID-19 vaccinations had been given in Devon by mid-March 2022, with the team rapidly accelerating the booster programme in December in response to the Omicron variant. Over 93% of Devon residents aged over 12 have had at least one COVID-19 vaccine dose. Spring boosters began in March and vaccinations for all 5-11s are due to be offered in early April.

NHS Devon Clinical Commissioning Group has worked closely with diverse communities to ensure the vaccine programme is accessible to all. Support materials have been provided in over 30 languages. 39,303 vaccinations have been given across 338 outreach clinics by February 2022. These include: local mosques; workplaces with large numbers of migrant workers; bespoke sessions for people with learning disabilities, experiencing homelessness, asylum seekers and undocumented migrants; a mobile vaccination unit targeting areas of deprivation and clinics run with the Devon & Cornwall Chinese Association in Plymouth and Exeter. 20 Vaccine ambassadors have been recruited and worked with hundreds of people from diverse communities acting as trusted community members providing accurate information.

The vaccination programme has run against a backdrop of often very high community rates of COVID-19, leading to a high number of inpatients with COVID-19, high sickness absence rates and outbreaks among adult social care providers through much of the year. This has continued to affect capacity across Devon's health and care system and impacted on work to reduce the elective backlog caused by the pandemic.

Despite these significant challenges, additional facilities have been introduced to support elective and diagnostic capacity including modular ophthalmology theatres at University Hospitals Plymouth NHS Trust and a mobile urology unit at Torbay and South Devon NHS Foundation Trust and NDHT. The design and location of the NHS Nightingale Hospital Exeter has allowed the building to be adapted for new uses, and it opened in March 2022 to provide diagnostic scans, orthopaedic theatres, an ophthalmology unit and rheumatology services.

Eastern Devon Local Care Partnership

The Eastern Devon Local Care Partnership is a good example of the way in which the Trust seeks to work together with partners.

For some time, it has been widely recognised that health and care services could be organised in a way that better meets the needs of the population. That is why the NHS, together with local councils, GPs, voluntary sector organisations and communities, are working differently by providing more care in people's homes and the community-breaking down barriers between services.

At the same time, we know that the NHS also needs to give greater priority to the prevention of ill health by working with partners to tackle both the wider

determinants of health and wellbeing, and the persistent and unacceptable health inequalities that remain rooted in the county. These inequalities have been bought to the fore by the pandemic. This will involve engaging the public in changing lifestyles and behaviours that contribute to ill health-acting on the recommendations of the Marmot report and other reviews to improve population health.

To make this a reality in Devon, the NHS and local authorities have established an Integrated Care System (ICS) covering all of Devon. The Devon ICS will take more control of funding and performance with less involvement by national bodies and regulators and will be based on the principle of co-operation and not competition. It is expected that this will be fully in place by July 2022.

The Devon ICS has established five Local Care Partnerships (LCP) covering specific sub-regions in Devon, one of which is the Eastern Local Care Partnership (see the green section on map below). The Eastern Local Care Partnership covers a large area from Axminister to Okehampton and includes Exeter, with a total population of around 400,000 people. The Eastern LCP is not a new organisation but a renewed partnership that, by aligning resources and efforts, will collectively seek to make a difference to the lives of people in East Devon and Exeter.

Why do we need an Eastern Local Care Partnership?

We know that there are a range of factors that impact people's health and wellbeing: their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live. We also know that much more can be achieved if we work together to magnify the assets and strengths that our communities have in abundance to help individual and collective wellbeing.

The Eastern LCP will work to connect people and services in ways that enable people to live healthy and happier lives. Building on the work already underway to enable all citizens to live well and get access to care and services when needed, the LCP will work to better join up hospital and community-based services, physical and mental health, and health and social care, whilst increasing the existing strengths of communities.

The LCP aims to:

- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system

What is the Eastern Local Care Partnership for?

The Eastern LCP will be driven by a common effort and ambition which will help align our collective actions to achieve outcomes that are 'greater than the sum of the parts'. It will do this by:

- Supporting what communities are already doing by providing resources, support or funding
- Building strong local relationships and connections
- Strengthening local voices by engaging on an on-going basis with local people in our villages, towns and cities, ensuring co-production is at the heart of what we do
- Being inclusive to ensure any individual, community or organisation can participate and get involved
- Using and making available in-depth and up-to-date insight into the assets and challenges of each of the unique coastal and market towns and the city
- Connecting the coastal and market towns and the city through sharing knowledge, insight, data and approaches to build a mutually-supportive network
- Embracing a federal approach, with each organisation across the LCP retaining its independence, identity and uniqueness, whilst collectively being part of a larger team which collaborates to identify and address shared purposes and aspirations.

There is no blueprint for this partnership and we understand that the relationships and approaches will need time to evolve as we develop trust between the various partners. However, we are equally aware that, collectively, we need to address the issues that confront us and make a real and tangible difference- not just talk about the problems.

What are the Eastern Local Care Partnership's main priorities?

There are four initial priority areas, based on some of the community conversations that have happened over recent years, and an analysis of public health data. These are:

1. Mental health-with a particular focus on loneliness
2. Support for unpaid carers
3. Prevention
4. Reducing pressure on urgent and emergency services

With the above in mind, the following three Prevention Network and Steering Groups have been created:

1. Loneliness & Isolation Prevention
2. Children & Young People Mental Health Prevention
3. Unpaid Carers' Prevention

Each network and steering group will have representation from a range of relevant statutory bodies, members of the voluntary sector, our communities and local people so that we can make a difference at a local level. How each plan will be delivered across our diverse range of rural and urban areas may differ but each will have the same guiding principles:

- Care and services will be wrapped around the individual
- We'll make it easy for people to understand how and where to access support
- We will ask "What matters to you?" rather than "What's wrong with you?"
- We see parity of esteem between mental and physical health
- We will apply the ethos of co-production- working with neighbourhoods, communities and organisations to achieve our vision
- We will be transparent and honest between ourselves and in our collective role across the LCP, basing our collective approach on the principle "best intent"
- We will be inclusive to ensure any individual, community or organisation can participate, contribute and shape in a way that is meaningful for them

What does it mean for the East Devon community?

We recognise that for the vast majority of people, the detail of how the NHS is organised and the partnerships it develops will be of limited interest. However, based on the conversations we have with local communities and our patients, we know that people want effective, high-quality services when they need them, they want a better solution to health and social care, they want parity of esteem between mental and physical health, and they understand that looking after your own health and wellbeing with appropriate support can help reduce the requirement for medical intervention.

The Eastern LCP has been established to deliver on these needs, and our intention is to continue to work in close alignment to support local community groups and involve people in the design of health and wellbeing initiatives.

What have we done during 2021/22

It is early days in the establishment of this new way of working, and the relationships that underpin it. Over the last 12 months, the Eastern Local Care Partnership has begun a journey to evolve and develop the place-based partnership and its collaborative arrangements between organisations arranging and delivering health, care and wider services in the locality. The development has taken place in the context of the White Paper on Integration; legislation formalising ICS arrangements through parliament; and the guidance released by NHSEI on the formation of the ICS structures. In considering the context, the Eastern LCP has sought to build on existing work in the locality and to use the permissive elements in the guidance to develop work across what is a demanding and extensive geography that includes market and coastal towns, a city, deeply rural communities, and an area with no established place-wide VCSE cooperation in situ.

As part of this evolution, the partnership has worked together on developing the role of the voluntary sector engagement in the partnership, and progressing work on the prevention priorities. This group has focused on:

- Putting in place the necessary governance and collaboration processes, including setting a vision and principles
- Developing plans to address the key population health management/prevention/health inequality issues in the locality
- The development of improved engagement and partnerships within the VCSE community
- Bringing together good practice and cementing relationships at the first Eastern LCP conference

The approach taken to nurture the trust-based partnerships has arguably been as, if not more important, than the concrete outcomes achieved in year one. The approach has gone a long way to establishing some of the core relationships required to sustain the new partnership and has laid the foundation for future cooperation.

In November 2021, the partnership held its first annual conference, bringing together over 100 representatives from the statutory and VCSE sectors in a virtual event. The conference was successful in bringing diverse actors together to broadly agree the direction of travel for the partnership, and in co-creating initial plans on key themes. It also helped demonstrate the strength and depth of the VCSE community and helped build momentum and commitment to the partnership. The conference initiated the development of joint plans to tackle key issues of particular relevance to this part of Devon: loneliness and social isolation; children and young people's mental health and unpaid carers.

Disclosures

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

The Trust has complied with Section 43 (2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The Trust's income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Income generated from the provision of goods and services for any other purposes is used by the Trust to provide healthcare services.

Remuneration report

The membership of the Remuneration Committee (RC) consists of the Chairman and all the Non-Executive Directors. During 2021/22, the RC for RD&E began to be held in common with NDHT, therefore the Non-Executive Directors from both RD&E and NDHT formed the membership for the latter part of the year.

The Chief Executive and, as necessary, other Executive Directors are invited to attend the RC in an advisory role but are excluded on issues directly relevant to them by the Chair of the Committee. The Committee is supported by the Chief People Officer and their senior team as required.

Prior to the meetings being held in common, Professor Janice Kay (Senior Independent Director), remained as the Chair with Mr Stephen Kirby remaining as Deputy Chair of the RD&E RC. The RC in common was co-Chaired by Professor Janice Kay and Tim Douglas-Riley (Senior Independent Director in NDHT) with each acting as deputies for one another.

In addition to the above, there have been four changes to the membership of the RC during 2021-22, with both Chris Bones and Hisham Khalil having left the Board of Directors in May 2021 and June 2021 respectively, and both Carole Burgoyne and Bridie Kent having joined the Board of Directors in June 2021.

The Committee's main purpose is to set rates of remuneration and terms and conditions of service for the Chief Executive, Executive Directors and Very Senior Managers (VSMs), who are remunerated on benchmarked salaries outside of nationally agreed pay scales. This encompasses those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust.

Formal adoption of RD&E and NDHT Remuneration Committee Principles & Terms of Reference took place during the RC in August 2021 along with sign off of the annual workplan. Additionally, a new VSM contract was reviewed by the RC in preparation for

the proposed integration of RD&E and NDHT.

Non-Executive Director and Chairman remuneration is dealt with by the Non-Executive Director Remuneration Committee (NEDRC, see page 142) and reports to the Board of Governors.

In-year remuneration decisions

The RC received feedback from NHSE/I in relation to the five Executive Director salaries that exceeded the £150k threshold and that were agreed by the RC in the last financial year. It was confirmed to the RC that they were able to proceed following comment from the Minister of State for Health, Edward Argar.

In 2020/21 a full benchmarking exercise for VSM employees on benchmarked salaries (excluding Executive Directors) was not carried out by the RC, in anticipation of the duly awaited national VSM pay framework. In the absence of this framework, in early 2021/22 the RC reviewed salaries for these employees based on the benchmarking data available at this time, resulting in three salary increases.

Further to the structure changes in the senior leadership team in the previous financial year to establish a joint leadership team across NDHT and RD&E, the RC also reviewed other leadership posts to ensure a consistency in approach across both Trusts, in particular gaining clarity on those that will and will not have their remuneration set on a benchmarked VSM salary outside of Agenda for Change (AfC) in the future.

The RC reviewed a set of criteria to ensure that the methodology is sustainable, fair and fit for purpose in the future as well as simplifying the current process where possible. This review resulted in a number of roles that had historically been paid as a VSM, albeit within the range of AfC, reverting to AfC pay scales.

Due to the lack of flexibility within the AfC ranges and to ensure no postholders were disadvantaged as a result of the change, the RC agreed that years of service would be accounted for and that staff would only transition to AfC once they aligned to an existing pay scale, so if a member of staff had been on a VSM salary in between the bottom and top point of a band, they would remain on their current salary until the requisite number of years-service have been reached to progress to the top pay point, and at this point they would revert to an AfC pay scale. The RC also agreed that these staff would receive cost of living increases each year in line with the AfC increase for their band to ensure they are not disadvantaged.

In September 2021 a letter was received by the Chairs of all NHS Trusts, NHS Foundation Trusts and CCGs clarifying the ministerial recommendation on 2021/22 annual pay increase for VSMs. This letter confirmed that there would be no increase to VSM salaries, owing to the Chancellors decision to introduce a temporary pause on pay rises for most public sector workforces in 2021/22. The Senior Salaries Review Body (SSRB) were therefore not asked to produce a pay recommendation for any senior managers in their remit, including the health sector.

It was confirmed to the RC that Trusts were able to use their discretion to make exceptional non-consolidated (one off) pay awards to acknowledge exceptional performance and that any awards must meet the criteria detailed in the letter. In summary that any increases must be budgeted, not exceed costs of more than 2% of the VSM pay budget and no individual award must be more that 5%.

The RC took the decision to write to all staff on a VSM contract to explain the situation on senior pay, the reasons this decision had been made nationally and to thank all of the Trusts senior leaders for their hard work. The RC confirmed to VSMs that the annual benchmarking exercise would still take place in order to ensure the Trust can retain an understanding of VSM pay against the wider NHS and to build evidence to support the RC in any remuneration decisions in future years.

The RC received the objectives and performance summary of the Chief Executive from the Chairman of the Trust in addition to that of the Executive Directors, reported by the Chief Executive. The RC reviewed remuneration information for the Trust's Chief Executive, Executive Directors and other VSM's using the benchmarking process agreed last year, including gender pay information on the national benchmarks. It was noted that the operating income for RD&E had increased to an extent where the Trust is close to the middle range of 'extra-large', meaning the median of this category was a more appropriate benchmark, as opposed to the lower quartile that was used last year.

Through this benchmarking process significant disparities were identified between the remuneration and benchmarking information available for six posts including two Executive Directors. The RC discussed performance summaries alongside remuneration information provided for those significantly below benchmark. It was identified that this would be an equality issue, particularly as the RC had made a commitment to several of these individuals to ensure that female employees who were below benchmark

in the previous year would be fairly remunerated in line with benchmarks in the future, subject to requisite experience and satisfactory performance. The RC made a balanced decision to award modest non-consolidated increases to the six individuals impacted, to reduce the gap between their current salaries and benchmark. The two executives who received non-consolidated increases were the Chief Finance Officer and the Chief People Officer.

The Chair of the RC reviewed and agreed the salary of the new Chief Operating Officer following the retirement of the previous post holder.

All decisions were made in accordance with the Remuneration Principles as set out below and considered benchmarking information from comparator Trusts using NHS Provider data, national median data provided by NHSE/I and individual performance data for each VSM. It should be noted that benchmarking data was not released by NHSE/I in 2020/21; therefore, this benchmarking was based on 2019/20 data plus 1.03% to account for the 2020/21 national cost of living uplift.

In addition, the options for cost of living uplifts were reviewed by the RC for all VSMs. In light of the national pay freeze the RC decided not to apply cost of living increases to VSMs in 2021/22.

NED attendance at RC meetings in 2021/22

The planned RC in July 2021 was deferred to August 2021, and the April 2021 meeting was split into two parts, with one part of the RC dedicated to RD&E business, the other part being joint with the NDHT RC to review shared items. All other RC meetings were held jointly with NDHT.

NAME	TRUST	23/04/21 (RD&E & NDHT)	23/04/21 (RD&E)	02/08/21 (RD&E & NDHT)	08/10/21 (RD&E & NDHT)	10/01/22 (RD&E & NDHT)
J Brent	RD&E & NDHT	P	P	P	P	P
J Kay	RD&E	P	P	A	P	P
T Douglas-Riley	NDHT	P		P	P	P
P Dillon	RD&E	P	P	A	P	A
S Kirby	RD&E & NDHT	P	P	P	P	P
H Khalil	RD&E	A	A			
A Matthews	RD&E	P	P	P	P	P
C Bones	RD&E	P	P			
T Neal	NDHT	A		P	P	P
R Down	NDHT	P		P	P	P
P Geen	NDHT	P		P	P	P
K Orford	RD&E & NDHT	P		P	P	P
C Burgoyne	RD&E			P	A	P
B Kent	RD&E & NDHT			A	P	P

P – Present, **A** – Apologies

Senior managers remuneration procedure

Remuneration principles

The agreed remuneration principles are listed as follows:

1. The Committee understands that its approach must strike an appropriate balance with its duty to ensure the effective stewardship of public resources. The Committee understands that senior level positions in the Trust operate in a regional/national context and that remuneration for these positions is primarily determined by the market. In order to remain competitive and attract and retain high calibre staff, the salaries of senior staff must be regularly reviewed to ensure that they remain broadly competitive and that the salaries offered to post holders do not degrade over time so that they are out of line with comparable Trusts. Nevertheless, the Committee will avoid paying more than is necessary to recruit, retain and motivate high calibre Executive Directors and Very Senior Managers and will take positions that are publicly defensible.

2. The Committee's approach to remuneration will seek to position the Trust in a way that it is able to attract, retain and motivate Executive Directors and Very Senior Managers of sufficient calibre to maintain high quality, patient-centred healthcare and effective management of the Trust's resources.

3. In reaching its determinations, the Committee will take proper account of National Agreements, for example Agenda for Change, and guidance issued by the Government, the Department of Health and the NHS market rates for comparable roles in comparable organisations.

4. The Committee will treat all people with equality and fairness when determining remuneration. It will seek to gain assurance that remuneration decisions do not exacerbate systemic pay issues.

5. The Committee will be rigorous in ensuring that potential conflicts of interest are recognised and avoided. Executive Directors and Very Senior Managers will not be involved in deciding their own remuneration package.

6. On an annual basis, the Committee will consider the remuneration packages of all Executive Directors and Very Senior Managers bearing in mind the performance of the Executive Directors and Very Senior Managers in fulfilling their duties and in regard to the overall performance of the Trust. The objectives set for the Executive Directors at appraisal and the progress against these will be shared with the Committee.

7. The Committee will consider external benchmark comparison data on the pay and conditions of Executive Directors and Very Senior Managers in comparator Trusts and other external organisations annually. This work will be undertaken on behalf of the RC by the Associate Director of People. The Committee will make judgements on where it wants to position its relative remuneration package for Executive Directors and Very Senior Managers.

8. The Committee will seek to apply the principles fairly and transparently and on the basis of data and advice from competent external bodies/ consultants or a senior HR advisor as necessary. The Committee understands that it will use the data it gathers and the framework set out in the principles to exercise the necessary judgment on pay and reward issues. The Committee will ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the organisation and will be based on judgements relating to:

   - Market rates for comparable roles
   - in comparable organisations
   - The size and scope of the role in question
   - Advice from the Chairman of the Trust in relation to the Chief Executive
   - Information from the Chief Executive in relation to the Executive Directors and Very Senior Managers
   - Affordability
   - Other NHS pay settlements
   - Wider implications that may arise from setting the remuneration packages of Executive Directors and Very Senior Managers in relation to pay levels determined through national agreements within the NHS
   - Performance against set objectives
   - Any other factors deemed appropriate

   The Committee will seek assurance that any pay differentials and / or variation from benchmarks are for justifiable reasons for example performance or experience. It will seek to ensure that the reasons for any variations are transparently communicated with individuals.

9. The Committee will seek to achieve broadly standardised terms and conditions for example on notice periods for all posts which fall within the scope of the principles.

10. The Committee will be transparent in the application of its remuneration principles. It is a requirement that details of the remuneration package for Board level Directors are recorded in the Trust's Annual Report.

11. The Trust recognises that the RC has the authorised responsibility to apply its independent judgement on matters within its remit within the wording and the spirit of the agreed principles. However, there may be times when a different approach is required which steps outside the scope of the principles and in these cases, particular care must be taken and clear justification must be given and recorded. Some circumstances which may require flexibility include temporary promotions; atypical employment conditions; specific issues related to individuals etc.

12. The Committee will reserve the right to recruit an Executive Director or Very Senior Manager on a salary below the market value in cases where a development plan would enable the employee to reach the minimum standards to undertake the role at a satisfactory level. The Committee also reserves the right to pay additional payments to Executive Directors and Very Senior Managers when deemed necessary because of exceptional circumstances. The occasions when additional payments are required will be limited. When considering using additional payments, the RC will need to be able to fully justify and explain why it has opted to take this course of action. It would only normally consider such action on the basis of a clear business case. Special care must be taken to ensure that the use of additional payments is completely transparent and that consideration has been given to the impact on pay inflation among Executive Directors and Very Senior Managers as well as to guard against accusations of bias or arbitrary practice.

13. The Committee will on an annual basis (in line with the Committee's work plan) ensure effective succession planning is in place for the Executive Directors and receive assurance from the Chief Executive that effective succession planning is in place for Very Senior Managers.

Scope

1. The principles will apply to the pay, awards and terms of employment of the Trust's Chief Executive, Executive Directors and Very Senior Managers and include the following components:

    - the core salary
    - any supplementary payments over and above the core salary in recognition of extraordinary factors such as matching market forces in recruitment; exceptional performance etc…
    - additional non-pay benefits over and above the core salary including pensions, vehicle/ lease car issues, mobile phones and other such benefits
    - the terms and conditions in regards to issues (such as notice periods, conditions attached at recruitment stage for professional development for example) etc…
    - arrangements for termination of employment and other contractual terms.

2. On an annual basis the Committee will consider whether any issues have emerged which require consideration of any adjustments to existing remuneration packages such as:

    - at the beginning of a process to recruit a replacement Executive Director or Very Senior Manager;
    - when issues concerning national inflationary uplifts within the NHS need to be considered – on an annual basis;
    - when changes are made to the size and scope of Executive Director or Very Senior Manager portfolios.

Process for benchmarking CEO, Executive Director & VSM salaries

Each year national benchmarking data is provided by NHSE&I and NHS Providers. This data is obtained via national salary survey submissions relating to the remuneration paid to Executive and Non-Executive Directors of all Trusts and Foundation Trusts operating in the UK. Typically, between 140 and 150 Trusts complete the return and data is collated into the annual dashboards. The Committee will use these sources of benchmark data to inform the discussion to decide remuneration for all Executive Director and Very Senior Manager positions.

For Very Senior Manager roles only, the annual benchmarking exercise will also benchmark VSM roles against the AfC pay parameters for Bands 8d & 9. This will ensure that VSM pay remains aligned to the top salary brackets offered in nationally agreed Agenda for Change pay scales or that salaries exceeding this are clearly justified.

It is recognised that for some non-clinical Executive Director and Very Senior Manager posts, the Trusts may wish to attract talent from non-NHS backgrounds. In order to ensure that the Trusts remain competitive and can attract non-NHS talent, Executive Director and Very Senior Manager salaries may be benchmarked against private and other non-NHS public sector organisations where high-quality comparator information is not available or where the regular benchmarking method produces unexpected results. Data sources to inform this benchmarking exercise will include national job boards, executive search salary data and other data sources that will be agreed with RC at the time of undertaking the benchmarking.

The Director of People will also provide analysis of the benchmarking data, history of individual's pay awards and any other data regarding current or planned NHS pay awards to inform the Committee.

The following table summarises the agreed approach to benchmarking for Executive and Very Senior Manager posts for RD&E and Joint posts:

Role Scope	NHSE / I Comparator	NHS Provider Comparator	Other Factors
Joint Executive Board (Including Director of Governance)	Supra Large Acute NHS and FTs median	Large Acute Foundation Trusts National Peer Average of total remuneration	
Joint Directors (e.g. Joint Director of Strategy)	Supra Large Acute NHS and FTs median	Large Acute Foundation Trusts National Peer Average of total remuneration	-15% to reflect the post is not board level
Site Director RD&E (e.g. RD&E Director of Nursing)	Extra Large Acute NHS and FTs median	Large Acute Foundation Trusts National Peer Average of total remuneration	-20% to reflect the post is not board level

Other information

The Chief Executive completes a formal annual performance review for all Executive Directors, and the Chairman reviews the performance of the Chief Executive. These reviews are reported to RC and, whilst the Trust does not currently operate a performance related pay scheme, these reviews are considered as a part of the review of remuneration.

The Executive Directors are appointed on permanent contracts and have a six-month notice period.

The Trust follows Agenda for Change (AfC) principles in calculating severance packages for redundancy. The redundancy payment will take the form of a lump sum, dependent on the employee's reckonable service at the date of termination of employment. The lump sum will be calculated on the basis of one month's pay for each complete year of reckonable service, subject to a minimum of two years' continuous service and a maximum of 24 years' reckonable service being counted. Fractions of a year of reckonable service will not be considered. For those earning over £80,000 per year (full time equivalent) the redundancy payment will be calculated using notional full-time annual earnings of £80,000, pro-rated for employees working less than full time. No redundancy payment will exceed £160,000 (pro-rata).

In accordance with the Agenda for Change Terms and Conditions of Employment, Executive Directors shall not be entitled to redundancy payments or early retirement on grounds of redundancy if:

- they are dismissed for reasons of misconduct, with or without notice; or
- at the date of the termination of the contract have obtained without a break, or with a break not exceeding four weeks, suitable alternative employment with the same or another NHS employer; or
- unreasonably refuse to accept or apply for suitable alternative employment with the same or another NHS employer; or
- leave their employment before expiry of notice, except if they are being released early; or
- they are offered a renewal of contract (with the substitution of the new employer for the previous NHS one); or
- where their employment is transferred to another public service employer who is not an NHS employer

Name and Title		Salary and Fees (bands of £5000)	Taxable Benefits (Rounded to the nearest £100)	Pension related Benefits (bands of £2500)	Other Remuneration (bands of £5000)	Golden hello/ compensation for loss of office (bands of £5000)	Gross Total (bands of £5000)	Recharges to Northern Devon Healthcare NHS Trust (bands of £5000)	Net Total (bands of £5000)
		£000	£	£000	£000	£000	£000	£000	£000
J Brent	Chairman *(resigned 31 March 2022)*	45-50	-	-	-	-	45-50	20-25	20-25
C Burgoyne	Non-Executive Director *(appointed 28 June 2021)*	10-15	-	-	-	-	10-15	-	10-15
B Kent	Non-Executive Director *(appointed 28 June 2021)*	10-15	-	-	-	-	10-15	-	10-15
K Orford	Non-Executive Director *(appointed 29 March 2021)*	10-15	-	-	-	-	10-15	-	10-15
C Bones	Non-Executive Director *(resigned 31 May 2021)*	0-5	-	-	-	-	0-5	-	0-5
P Dillon	Non-Executive Director *(resigned 31 March 2022)*	10-15	-	-	-	-	10-15	-	10-15
J Kay	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
H Khalil	Non-Executive Director *(resigned 02 June 2021)*	0-5	-	-	-	-	0-5	-	0-5
S Kirby	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
A Matthews	Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
H Foster	Chief People Officer	140-145	-	-	-	-	140-145	70-75	70-75
A Harris	Chief Medical Officer	210-215	-	57.5-60.0	-	-	270-275	135-140	135-140
A Hibbard	Chief Financial Officer	160-165	-	80.0-82.5	-	-	240-245	120-125	120-125
C Mills	Chief Nursing Officer	155-160	-	97.5-100.0	-	-	255-260	125-130	125-130
J Palmer	Chief Operating Officer *(appointed 12 April 2021)*	105-110	-	32.5-35.0	75-80	-	215-220	105 -110	105-110
C Tidman	Deputy Chief Executive	175-180	-	117.5-120.0	-	-	295-300	145-150	145-150
S Tracey	Chief Executive	240-245	-		-	-	240-245	120-125	120-125

It should be noted that the above Executive Director salaries reflect the appointment of the Joint Executive team that was agreed in the previous financial year, in preparation for the integration of the Trusts. Due to the size of the combined Trust, benchmarking for these posts was based on a 'supra-large' Trust and resulted in some increases in salary.

Whilst no bonuses were paid to any individual in the 2021/22 financial year, non-consolidated payments were made to the Chief Finance Officer and Chief People Officer to reflect that these roles were significantly below benchmark when compared to their colleagues. This reflects a commitment made by the RC in 2020/21, to ensure that female employees who were below benchmark in the previous year would be fairly remunerated in line with benchmarks in the future, subject to requisite experience and satisfactory performance.

The Chief Operating Officer joined the RD&E and NDHT as an interim in April 2021, before being appointed substantively as Chief Operating Officer in July 2021. The agency costs associated with this period are detailed within the 'other remuneration' section of the above table. As part of the substantive appointment a taxable accommodation allowance for a two-year period was agreed and is included in the salary and fees column. The 'other remuneration' column details the costs incurred during the interim period.

There are no benefits in kind reported this year relating to the mileage allowance paid over and above the HM Revenue & Customs allowance for Executive Directors as this is now taxed at source.

The final column discloses the net total remuneration for each Director in respect of their duties for the RD&E.

Directors remuneration 2020/21 (information in this section is subject to audit)

Name and Title		Salary and Fees (bands of £5000)	Taxable Benefits (Rounded to the nearest £100)	Pension related Benefits (bands of £2500)	Other Remuneration (bands of £5000)	Golden hello/ compensation for loss of office (bands of £5000)	Gross Total (bands of £5000)	Recharges to Northern Devon Healthcare NHS Trust (bands of £5000)	Net Total (bands of £5000)
		£000	£	£000	£000	£000	£000	£000	£000
J Brent	Chairman	45-50	-	-	-	-	45-50	20-25	20-25
J Ashman	Non-Executive Director *(resigned 30 September 2020)*	5-10	-	-	-	-	5-10	-	5-10
C Bones	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
P Dillon	Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
J Kay	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
H Khalil	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
S.Kirby	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
A Matthews	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
P Adey	Chief Operating Officer *(resigned 31 March 2021)*	155-160	-	37.5-40	-	-	195-200	85-90	110-115
H Foster	Director of People	140-145	-	-	-	-	140-145	65-70	70-75
A Harris	Executive Medical Director	210-215	-	112.5-115	-	-	325-330	140-145	185-190
A Hibbard	Chief Financial Officer *(appointed 1 January 2021)*	35-40	-	67.5-70	-	-	105-110	50-55	55-60
C Mills	Chief Nursing Officer *(appointed 18 January 2021)*	30-35	-	7.5-10	-	-	35-40	15-20	15-20
D Thomas	Interim Chief Nurse *(resigned 18 January 2021)*	100-105	-	120-122.5	-	-	220-225	-	220-225
C Tidman	Deputy Chief Executive *(appointed 1 January 2021)*	165-170	-	90-92.5	-	-	255-260	35-40	220-225
S Tracey	Chief Executive	230-235	-	62.5-65	-	-	295-300	145-150	145-150

There were no annual performance-related bonuses or long-term performance-related bonuses paid to any individual in the financial year.

The Payment Settlement Agreement with HMRC under which Non-Executive Directors official mileage was paid and the Trust made payments for Tax and NI based on grossed up figures ceased with effect from 31st March 2019, as per HMRC regulations. All Non-Executive mileage over HMRC threshold is now taxed at source.

The remuneration shown in the 'Recharges to NDHT column for J Brent, P Adey, H Foster, A Harris, A Hibbard, C Mills, C Tidman and S Tracey relates to their roles as Directors under a collaborative agreement with NDHT, which commenced on 18th June 2018.

The final column discloses the net total remuneration for each Director in respect of their duties for the Royal Devon & Exeter NHS Foundation Trust.

Ratio between highest paid Director and median remuneration received by employees of the Trust

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. In addition, the 25th and 75th percentile ratio is also now required to be reported.

The banded remuneration of the highest paid director in the organisation in the financial year 2021- 22 was £120-£125k (2020-21 was £140-£145k). This was 3.8 times (2020-21, 4.6 times) the median remuneration of the workforce, which was £32.4k (2020-21, £30.8k).

In 2021-22, 239 (2020-21, 75) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £122k-£239k (2020-21 was £145k-£244k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The calculation is based on the full-time equivalent staff of the Trust at the reporting period end date on an annualised basis. Where there is a sharing arrangement, it is cost to the entity of an individual that identifies them as "highest paid" and not the total of that individual's remuneration.

The Chief Executive Officer is the highest paid Director for the purposes of the calculation. The national pay deal is responsible for the change in median pay for employees.

	2021/22	2020/21
	£000	£000
Band of highest paid Director-as above	120-125	140-145
25th percentile remuneration received by employees within the Trust	23.3	30.8
Median remuneration received by employees within the Trust	30.8	
75th percentile remuneration received by employees within the Trust	42.7	
25th percentile ratio	5.3	4.6
Median Ratio	3.8	
75th percentile ratio	2.9	

Pension related benefits for defined benefit schemes:

The amount included is the annual increase (expressed in £2,500 bands) in pension entitlement determined in accordance with the 'HMRC' method. The HMRC method derives from s229 of the Finance Act 2004, but is modified for the purpose of this calculation. In summary the increase in value is calculated as follows:

(20 x PE) + LSE) – (20 x PB) + LSB)-employee contributions.

- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;
- and LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related lump sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2021	Real Increase in Cash Equivalent Transfer Value at 31 March 2022
		£000	£000	£000	£000	£000	£000	£000
H Foster	Chief People Officer	-	-	-	-	-	-	-
A Harris	Chief Medical Officer	2.5-5.0	7.5-10.0	75-80	235-240	1,954	1,814	99
A Hibbard	Chief Financial Officer	2.5-5.0	5.0-7.5	35-40	55-60	525	445	55
C Mills	Chief Nursing Officer	5.0-7.5	15.0-17.5	65-70	195-200	1,519	1,360	130
J Palmer	Chief Operating Officer *(appointed 12 April 2021)*	0.0-2.5	-	15-20	-	207	164	11
C Tidman	Deputy Chief Executive	2.0-2.5	2.5-5.0	65-70	160-165	1,275	1,140	44
S Tracey	Chief Executive	-	-	-	-	-	-	-
S Tracey	Chief Executive	2.5-5	2.5-5	50-55	100-105	1000	902	62

Supporting notes re table above;

Hannah Foster joined the pension scheme for part of the year, but then opted out and took a refund from NHS Pensions so no amounts are included in relation to pension for her.

Chris Tidman opted out of the pension scheme 31.8.2021.

Suzanne Tracey opted out of the pension scheme on 30/11/2020.

John Palmer is a member of the 2008 section and the 2015 scheme and has no mandatory lump sum

A number of Executive Directors have opted out of the pension scheme and it is important to note that these individuals receive no payment in lieu of pension contributions.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular 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 as a consequence 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 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 as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV-this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Cash Equivalent Transfer Values (CETV) are not available for members that have reached the normal retirement age or who have commenced drawing their pension or are a deferred member.

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related lump sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2021 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2020	Real Increase in Cash Equivalent Transfer Value at 31 March 2021
		£000	£000	£000	£000	£000	£000	£000
P Adey	Chief Operating Officer *(resigned 31 March 2021)*	2.5-5	0-2.5	65-70	155-160	1396	1298	51
H Foster	Director of People	-	-	-	-	-	-	-
A Harris	Executive Medical Director	5-7.5	17.5-20	75-80	225-230	1814	1597	159
A Hibbard	Chief Financial Officer *(appointed 1 January 2021)*	0-2.5	0-2.5	30-35	50-55	445	374	11
C Mills	Chief Nursing Officer *(appointed 18 January 2021)*	0-2.5	0-2.5	60-65	180-185	1360	1279	6
D Thomas	Interim Chief Nurse *(resigned 18 January 2021)*	2.5-5	7.5-10	40-45	100-105	764	638	77
C Tidman	Deputy Chief Executive *(appointed 1 January 2021, previously Chief Financial Officer)*	2.5-5	7.5-10	60-65	150-155	1140	1018	91
S Tracey	Chief Executive	2.5-5	2.5-5	50-55	100-105	1000	902	62

Supporting notes re table above;

Hannah Foster joined the pension scheme for part of the year, but then opted out and took a refund from NHS Pensions so no amounts are included in relation to pension for her.

Chris Tidman opted in to the pension scheme 01/04/20-30/06/20, opted out, and then back in 01/12/2020-31/03/2021.

Suzanne Tracey opted out of the pension scheme on 30/11/20.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular 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 as a consequence 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 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 as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

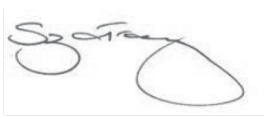
Real increase in CETV-This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Cash Equivalent Transfer Values (CETV) are not available for members that have reached the normal retirement age or who have commenced drawing their pension or are a deferred member.

Future remuneration policy table

Element of pay (Component)	How component supports short and long term strategic objective/ goal of the Trust	Operation of the component	Performance metric used and time period
• Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives outlined in its annual priorities and its long term strategic goals	Following market testing (undertaken every year) which seeks to identify salary paid for similar role, individuals are remunerated by spot salary on a case by case basis. There is no predefined upper limit. In accordance with the NHSI Guidance on pay for very senior managers in NHS trusts and Foundation Trusts the Chief Executive Officer contract includes a clause permitting 10% of salary to be clawed back if performance is not considered to be satisfactory.	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March. Increases are ordinarily in line with the wider NHS workforce as recommended by the NHS Pay Review Body.
• Benefits	N/A	N/A	N/A
• Pension	Provides a solid basis for recruitment and retention of top leaders in sector.	Contributions within the relevant NHS pension scheme. Details of the schemes currently in place can be found at: http:// www.nhsbsa.nhs.uk/ Pensions.aspx	Contribution rates are set by the NHS Pension Scheme.
• Bonus	N/A	N/A	N/A
• Fees	N/A	N/A	N/A

Signed:



Suzanne Tracey
Chief Executive Officer
Date: 08 June 2022

Staff Report

The most important asset for health and social care is the people who deliver it. Yet the NHS faces significant challenges in having a workforce that has the right skills in the right places, that is not overloaded or stressed, and that is motivated and empowered. These challenges were further compounded in 2020/21 by the unprecedented effects of COVID-19.

Over the following pages the Trust will share some of the key initiatives it has introduced to support and enable our people to give of their best, delivering the high-quality services our communities expect and deserve.

Trust thanks

The Trust would like to thank all staff, volunteers and Governors who contribute so much every day to making the RD&E a great organisation, always striving to do the right thing for our patients, people and communities.

Recruitment

Workforce remains the most important asset for health and social care and this has continued to be tested to the limit during the pandemic. Not only have there been the usual challenges of vacancies and general sickness; added pressure has come from increased difficulties in recruiting, with the national picture showing the lowest rates of unemployment for some time, together with unprecedented levels of jobs being competitively advertised.

In recruitment terms, 2021 has been a significant year and candidate expectations have radically changed. Technology has never played such an important role in the attraction, selection and appointment of new candidates and the competition for talent has never been so fierce. The two Trusts (RDE and NDHT) have reviewed options for a replacement recruitment system, with progress being made towards procurement of a commercial product. This will provide a robust applicant tracking system with ability to automate manual processes, reduce the time to hire process, improve the candidate engagement experience and link with other external systems without further need for human intervention. The Trusts are scheduled for go live in summer 2022, following a period of testing.

Linked with improved recruitment technology and the introduction of the Executive & Specialist Recruitment Team the Trust has set up monthly 'Hard to Fill' meetings attended by senior divisional representatives. In these meetings, key information is shared by the division on its most challenging recruitment issues in order to gain an understanding of the issues and requirements, to enable innovative recruitment approaches to be trialled and to ultimately recruit to these posts. Such examples include making good use of social media technology and advertising; selecting and attending key recruitment fairs and events, making good use of staff referrals and recommendations, and extensive use of the new Executive and Specialist Recruitment Team, who search for candidates worldwide and identify shortlists of quality candidates. In addition, the creation of the Devon International Recruitment (IR) Hub across the Devon Integrated Care System (ICS) has provided additional access to overseas registered nurses.

The Trust has also led on the development of a system-wide Memorandum of Understanding (MOU) which passports staff around the ICS negating the need for redoing pre-employment checks. This has been invaluable during the pandemic and is further being strengthened by the drafting of a single contract of employment and related staff documents in order that our workforce have as seamless an employment journey as possible. Other ICS work the Trust has engaged in is the building of a Medical Collaborative Bank and continuing with its collaborative approach to Temporary Staffing solutions.

Sickness

The Trust has battled against severe sickness levels throughout much of the last year, with only small reprieves from COVID related absence. Close scrutiny on sickness trends, causes and highest impacted areas has led to focused actions through the introduction of a weekly Staffing Hub meeting and multiple times per week during peak absence periods. This has enabled the implementation of dynamic interventions across the key staff groups affected to ensure sufficient staffing numbers to care for our patients.

Complimenting the Staffing Hub has been the support from the HR COVID Absence Hub and Occupational Health (OH) who have focused their attention on bringing staff safely back to work.

Retention and attrition

Retention and attrition at the Trust has been of paramount importance during the pandemic and this has led to the creation of a Task and Finish

Group across the ICS to introduce a number of recommendations to improve retention rates. Initiatives already adopted have included improved access to flexible working, increased levels of retire and return, use of a 'Transfer Window' allowing registered nurses and HCAs an opportunity to change specialty, improved learning and development opportunities to support promotion and change of role/career (i.e. Domestics, Catering and Laundry staff becoming Healthcare Support Workers) and improved parking solutions including the continuation of free parking.

Staff consultation and partnership working

The Trust has continued to strengthen partnership working with Staffside colleagues for the benefit of improving the working lives of our people. Staffside representatives also attend many committees and steering groups that impact on staffing such as the People, Workforce Planning and Wellbeing Committee, Trust's Morale Programme Group, COVID Safe Group, Space Utilisation and Travel Groups. We make significant efforts to listen to and meaningfully consult with staff from all areas. This involves senior managers meeting with Staffside representatives from a broad range of Trade Unions on a monthly basis at the Partnership Forum.

Some of the key issues regularly discussed in the last 12 months include:

- COVID-19 testing, vaccination, risk assessments and associated absence
- Management of Change (all) and specifically integration with NDHT
- Staff survey results and associated action plans
- HR policies
- Recruitment challenges, retention, job evaluation and pay (including local pay elements)

Appointment to lead Freedom to Speak Up Guardian

The Trust has appointed a Lead Freedom to Speak Up Guardian (FTSUG) to strengthen the role of the FTSUGs, to promote the support that can be offered to any staff member in need of a listening ear and to help them to reach successful resolution.

Staff numbers

Note 5.3 Average number of employees (WTE basis)	Expected sign	A09CY01 Total Accounts 2021/22 No.	A09CY01P Permanent Accounts 2021/22 No.	A09CY01O Other Accounts 2021/22 No.	A09PY01 Total Accounts 2020/21 No.	A09PY01P Permanent Accounts 2020/21 No.	A09PY01O Other Accounts 2020/21 No.	Maincode / Subcode
Medical and dental	+	**948**	930	18	**921**	902	19	**STA0370**
Ambulance staff	+	**2**	2		**2**	2		**STA0380**
Administration and estates	+	**1,559**	1,452	107	**1,600**	1,481	119	**STA0390**
Healthcare assistants and other support staff	+	**2,788**	2,494	294	**2,755**	2,504	251	**STA0400**
Nursing, midwifery and health visiting staff	+	**2,195**	2,105	90	**2,107**	2,031	76	**STA0410**
Nursing, midwifery and health visiting learners	+	**16**	16		**16**	16		**STA0420**
Scientific, therapeutic and technical staff	+	**81**	778	23	**770**	752	18	**STA0430**
Healthcare science staff	+	**212**	212		**209**	209		**STA0440**
Social care staff	+	**0**			**0**			**STA0450**
Other	+	**13**	13		**15**	15		**STA0480**
Total average numbers	+	**8,534**	**8,002**	**532**	**8,395**	**7,912**	**483**	**STA0490**
Of which:								
Number of employees (WTE) engaged on capital projects	+	**5**	5		**146**	144	2	**STA0500**

Staff numbers continue to increase, by over 5% over the last year. Much of that growth is due to the Trust recruiting additional un-registered nursing & support staff. In a challenging environment for recruiting healthcare professionals, the Trust's workforce has seen a net increase of 84 nurses & 61 doctors compared with the same point a year ago.

Staff costs

Staff costs for 2021/22 and 2020/21 are summarised in the table below.

Note 5.2 Employee Expenses (Group **after** consolidation of charity)	A09CY01 **Total 2021/22 £000**	A09CY01P **Permanent 2021/22 £000**	A09CY01O **Other 2021/22 £000**	A09PY01 **Total 2020/21 £000**	A09PY01P **Permanent 2020/21 £000**	A09PY01O **Other 2020/21 £000**
Salaries and wages	324,631	322,643	1,988	316,945	315,399	1,546
Social security costs	30,430	30,430	0	27,955	27,955	0
Apprenticeship levy	1,601	1,601	0	1,503	1,503	0
Pension cost - employer contributions to NHS pension scheme	39,100	39,100	0	37,308	37,308	0
Pension cost - employer contributions paid by NHSE on provider's behalf	17,117	17,117	0	16,337	16,337	0
Pension cost - other	230	230	0	225	225	0
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	67	67	0	148	148	0
Temporary staff - external bank	0	0	0	0	0	0
Temporary staff - agency/contract staff	10,610	0	10,610	8,152	0	8,152
NHS charitable funds staff	0	0	0	0	0	0
TOTAL GROSS STAFF COSTS	423,786	411,188	12,598	408,573	398,785	9,698
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0	0	0
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	0	0	0
TOTAL STAFF COSTS	**423,786**	**411,188**	**12,598**	**408,573**	**398,875**	**9,698**
Cost capitalised as part of assets	315	315	0	7,252	7,252	0
Total employee benefits excl. capitalised costs	423,471	410,873	12,598	401,321	391,623	9,698

Note 6.1 Reporting of other compensation schemes - exit packages 2021/22 Note that columns G, I and M are entered in £000. NHS Trusts - note that the GAM advises local accounts should be in £		A09CY17 Number of compulsory redundancies 2021 /22	A09CY18 Cost of compulsory redundancies 2021 /22	A09CY19 Number of other departures agreed 2021 /22	A09CY20 Cost of other departures agreed 2021 /22	A09CY21 Total number of exit packages 2020 /21	A09CY22 Total cost of exit packages 2020 /21	A09CY23 Number of departures where special payments have been made 2020 /21	A09CY24 Cost of special payment element included in exit packages 2020 /21	Maincode
	Expected sign	No.	£000	No.	£000	No.	£000	No.	£000	Subcode
Exit package cost band (including any special payment element)										
<£10,000	+	3	10	21	65	24	75			STA0560
£10,000 - £25,000	+			1	13	1	13			STA0570
£25,001 - £50,000	+			1	29	1	29			STA0580
£50,001 - £100,000	+	1	57			1	57			STA0590
£100,001 - £150,000	+					0	0			STA0600
£150,001 - £200,000	+					0	0			STA0610
>£200,000	+					0	0			STA0620
Total	**+**	**4**	**67**	**23**	**107**	**27**	**174**	**0**	**0**	STA0630

Note 6.1 Reporting of other compensation schemes - exit packages 2020/21 Note that columns G, I and M are entered in £000. NHS Trusts - note that the GAM advises local accounts should be in £	Expected sign	A09CY17 Number of compulsory redundancies 2020 /21 No.	A09CY18 Cost of compulsory redundancies 2020 /21 £000	A09CY19 Number of other departures agreed 2020 /21 No.	A09CY20 Cost of other departures agreed 2020 /21 £000	A09CY21 Total number of exit packages 2020 /21 No.	A09CY22 Total cost of exit packages 2020 /21 £000	A09CY23 Number of departures where special payments have been made 2020 /21 No.	A09CY24 Cost of special payment element included in exit packages 2020 /21 £000	Maincode Subcode
Exit package cost band (including any special payment element)										
<£10,000	+			8	34	8	34			STA0560
£10,000 - £25,000	+			2	24	2	25			STA0570
£25,001 - £50,000	+	1	47	1	30	2	77			STA0580
£50,001 - £100,000	+					0	0			STA0590
£100,001 - £150,000	+	1	101			1	101			STA0600
£150,001 - £200,000	+					0	0			STA0610
>£200,000	+					0	0			STA0620
Total	**+**	**2**	**148**	**1**	**88**	**13**	**235**	**0**	**0**	STA0630

Redundancy is based on one month's pay for each completed year of reckonable service (between 2 and 24 years).

PILON is based on the notice period held within the employees' contract of employment and can range from 1 month to 3 months basic pay

A settlement agreement will be made following an Employment Tribunal in conjunction with Trust Solicitors advice on amount to be paid.

Gender equality (information in this section is not subject to audit)

The Trust is committed to achieving equality and diversity in all that we do, for our staff and in the services they provide. The numbers of male and female employees at 31 March 2022 is reported in the table below.

	Female	Male	Total
Directors	8	8	16
Employees*	7,203	2,087	9,290

* The figure for employees is the total number of employees as opposed to the whole time equivalent reported in the staff number section above.

In line with statutory reporting the Trust publicly reported its gender pay gap report in line with requirements. This is available via gender-pay-gap.service.gov.uk.

The data required to be reported by 31st March 2022 was a snapshot of our data from 31st March 2021. The data shows women occupy **68.5%** of the highest paid jobs and **80.1%** of the lowest paid jobs and women's median hourly wage is **9.3% lower** than men.

Much of the Trust's pay is aligned to national pay agreements and the gender pay gap is similar to other NHS hospital organisations where there is a higher proportion of men in senior medical roles and greater numbers of women roles at lower bands.

Actions are in place seek to reduce the gap in areas within the control of the trust.

Sickness absence

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
7,908	85,862	2,866,378	139,288	10.9

Source: NHS Digital-Sickness Absence and Workforce Publications-based on data from the ESR Data Warehouse. Period covered: January to December 2021

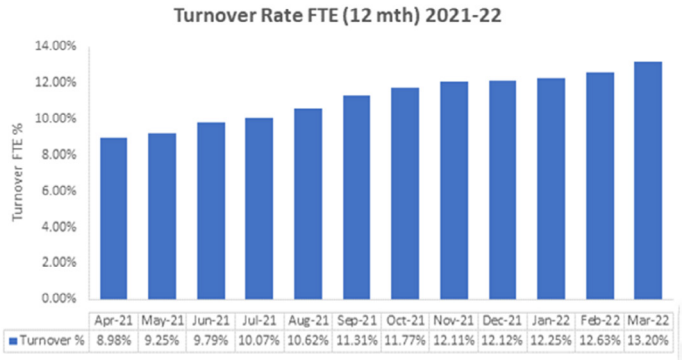
Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of 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.

Trust turnover



The turnover rate increased during the year, passing the Trust's planned-for 12% by year end. Whilst turnover had been on a downward trend for much of the previous 24 months, the figure has latterly reached and exceeded the level seen at the beginning of the pandemic. Though no singular factor can be attributed to the higher turnover seen in recent

months, we are seeing a challenge in retention and recruitment across the sector, particularly in the case of healthcare support workers-a pattern echoed throughout our region and the across NHS. In collaboration with our ICS partners, the Trust is fully engaged in NHS Improvement's programmes and plans to support and grow our workforce.

Disability

The Equality Act 2010 defines disability, and makes it clear that a person is disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities. The Board has reviewed our approach to inclusion as described in the Diversity and Inclusion section of the Annual Report. The Trust is already taking a variety of actions to support both existing staff and applicants wishing to join the Trust.

The Chief People Officer is personally responsible for ensuring that the Trust complies with equality law and any relevant NHS standards for the promotion and assessment of equality. This reflects the importance placed by the Trust on the proper and equitable treatment of all applicants, workers and service users regardless of disability. All staff undergo equality and diversity training, raising awareness of personal and Trust responsibilities to those with any protected characteristic, including disability, and this training continues to be expanded.

The core Trust Policy that applied during the financial year is the Equality and Diversity Policy. This policy gives full and fair consideration to applications for employment made by disabled persons relating to their particular aptitudes and abilities, for continuing the employment and arranging appropriate training for employees who have become disabled persons during the period, and for the training, career development and promotion of disabled employees. This policy is due for review in May 2022.

The ultimate aim of the policy is to harness the individuality of every employee, so everyone is fully engaged in the work of the Trust, and to protect all workers and service users from all forms of discrimination, harassment and victimisation on the basis of any protected characteristic.

The Trust is an NHS Employers Diversity and Inclusion Partner and continues to enact the D&I agenda, including disability, at a National level.

Staff who become disabled

Whenever possible, we support staff to either prevent or minimise the impact of any disability on the ability to work. Early discussions with line managers, and referrals to the Occupational Health Service, are encouraged so that action can be taken to aid rehabilitation and return to work following illness or injury, making any reasonable adjustments that can assist.

Actions taken to assist staff who develop a disability include provision of additional software, specially adapted hardware or larger screen to facilitate use of technology, adjustments to desks or chairs, through to job redesign, to enable a person to continue working.

Members of the ER Team have undertaken a Level 2 Certificate in Understanding Specific Learning Difficulties.

The Trust also has access to an Online Assessment Tool which is completed by an employee. This produces a report which identifies whether dyslexia is indicated, and provides a range of recommendations and further references to be discussed with the line manager, supported by HR. The best way to provide external support may be through Access to Work, but the employee will also have a list of self-help recommendations.

The Stress Management: Prevention, Recognition and Support Policy is supported with an extensive Manager's Toolkit to help managers have a positive impact on the health and wellbeing of employees.

The Trust also has a number of 'Freedom to Speak up Guardians' in post across grades and divisions. The FTSUG roles have been undertaken alongside holding a substantive role elsewhere in the Trust; however the importance of these roles has been recognised with the recent appointment of a whole time FTSUG, to be dedicated solely to this work.

The FTSUG's work with senior management, including the Trust's Inclusion Lead, in the organisation to help develop a culture in which staff feel able to "speak up" if they feel that the Trust's values are being compromised.

Recruitment

The Trust's Recruitment and Selection Policy is designed to ensure that recruitment is carried out in accordance with the Equality Act 2010. Its aim is to ensure that applicants feel that they have been dealt with professionally, fairly and that they feel that the Trust values its staff.

The Trust is accredited by Jobcentre Plus to use the 'Disability Confident Employer' symbol. This means that the Trust will:

- interview all applicants with a disability who meet the minimum criteria for a position, and consider them on their abilities
- consult with employees with a disability about how the Trust can help develop their abilities
- make every effort when employees acquire a disability to make sure they stay in employment
- take action to ensure that all employees develop sufficient awareness of disability to make these commitments work
- review these commitments and plan on ways to improve them.

All applicants asked to attend a selection process (whether face to face or via MS Teams) are invited to provide details on any reasonable adjustments that they require so that these can be implemented.

Once a conditional offer of employment has been made, all applicants for employment with the Trust complete an online Health Questionnaire as part of the conditional offer process that is reviewed by the Occupational Health Service (OHS). If issues are identified, the individual will be invited to attend the OHS where an assessment is completed and recommendations are made to the recruiting Line Manager so that whenever possible the person may be employed safely and with the necessary adjustments in place to enable them to carry out the role.

Experts from both the Occupational Health Service and Human Resources are available to provide advice on reasonable adjustments and guidance to managers during and after the recruitment process.

The coronavirus pandemic has also brought with it unprecedented challenges, with the Trust having to adapt quickly to ensure that colleagues can work safely and efficiently and that patient safety is not adversely impacted.

The flexibility that has been demonstrated in the Trust, and the changes that have been made to many ways of working, present opportunities to adapt to the needs of our disabled employees in future.

The understanding that many managers have gained during the pandemic will help inform how employees can balance their home and work responsibilities, and what adjustments might be needed in the workplace.

During the probationary period of a new employee to the Trust, the line manager will ensure that reasonable adjustments are provided as appropriate at the commencement of employment. During each of the subsequent review meetings, line managers will consider the adjustments required to support the employee's disability throughout the process. If line managers require further guidance on the Equality Act and Disabilities, they can contact a member of the Employee Relations Team (ER Team).

The ER Team provides a wealth of guidance and signposting to managers and employees to both internal and external resources; including reference to the 'Managing My Health at Work' booklet, which is a practical guide for staff experiencing stress, anxiety or depression.

Support for employees psychological wellbeing

The Trust continued to provide extensive psychological support services as the pandemic continued through its second year. The dedicated provision for this support has been driven by the multi-disciplinary Psychological Support Working Group consisting of key internal stakeholders, but has also extended across partner organisations with collaboration to ensure optimal use of resources and timely support for employees.

The Occupational Health and Wellbeing team has provided a wide range of psychological intervention to groups and individuals, ranging from fitness to work advice related to psychological conditions by specialist Occupational Health Advisers or Physicians, one-to-one counselling provided by the in-house counselling team, specialist sleep advice and sleep coaching, whilst also responding to a consistently high volume of contacts due to COVID-related anxiety.

Support has also been provided in the form of on-site 'Wellbeing Ward Rounds' at the request of managers, and team support provided. Health and Wellbeing Champions continue to be a valued resource embedded within the organisation.

In addition to these services, the staff counselling team provides trauma therapy within NICE Guidelines and the BACP Ethical Framework. Trauma support is also provided in the form of TRiM, with a considerable number of Trauma Incident Briefings delivered across the Trust in the last year. Mental Health First Aid and stress awareness courses continue to be delivered within the parameters of COVID, and employees continue to have access to an Employee Assistance Programme.

The Occupational Health and Wellbeing team aim to consolidate both TRiM and Mental Health First Aid with intention to increase the accessibility and delivery of these courses across the Trust, facilitating a culture of prevention and early intervention and enhanced psychological support for all employees.

The Occupational Health and Wellbeing team has provided extensive support regarding employees return to work with its COVID testing advice team, and were also integral to the large-scale vaccination programme, as well as the recruitment clearances associated with these.

Mindful employer

The Trust continues to hold the Mindful Employer accreditation for the way we promote good mental health among our employees. The Mindful Employer scheme delivers against the following aims:

- show a positive and enabling attitude to employees and job applicants with mental health issues. This will include positive statements in local recruitment literature
- ensure that all staff involved in recruitment and selection are briefed on mental health issues and the Equality Act, and given appropriate interview skills
- make it clear in any recruitment or occupational health check that people who have experienced mental health issues will not be discriminated against, and that disclosure of a mental health issue will enable both employee and employer to assess and provide the right level of support or adjustment
- not make assumptions that a person with a mental health issue will be more vulnerable to workplace stress, or take more time off than any other employee or job applicant
- provide non-judgemental and proactive support to individual staff who experience mental health issues
- ensure all line managers have information and training about managing mental health in the workplace

The Trust remains wholly committed to continuous improvement with regards to our Mental Health approach, with further plans to consolidate Mental Health training with implementation of a robust MHFA programme targeted at the 1,000 identified supervisors and managers complimented with considerable stress awareness and stress indicator programmes, with a view to normalising mental health first aid in the same way as physical first aid. In addition, a wellness passport is currently under development to enable easy and supported transition throughout the workplace if changing roles within the organisation.

Valuing and developing our people

Employee experience and cultural development

The Board of Directors has confirmed that they are fully committed to embedding a Just & Learning Culture, providing a clear direction for the Trust for the future. The Trust has already begun this journey with streams of work including amending the processes for disciplinary and grievance cases with a view to reduce the number of formal cases, development of an Employee Relations (ER) dashboard to monitor the impact of these changes and the drafting of a new 'Code of Conduct' with accessible simplified policies that will be part of year 1 integration work.

In addition, engagement with the wider teams has taken place with the roll-out of the quarterly People Pulse survey to understand staff perception of the current culture and also to understand their vision for the future organisation. A restorative justice development has been implemented, which will support the creation of Just and Learning Champion's that will embed the principles of a just and learning culture into our operational processes and ways of working, as well as drive the shift in culture. Culture Clubs have also been set up and are open to all staff with each session focussing on a different topic.

A key part of Employee Experience is ensuring that staff are heard. The Board now receive an annual staff voice and partnership working report that is presented by Staffside.

People development

The past year has been a significant one for People Development in the RD&E.

We have been working collaboratively with our colleagues at NDHT on the creation of the new joint Learning Management System (LMS). This has been called Learn+, which is live in NDHT and will be live in the RD&E in summer 2022. Learn + has been designed to be a user-friendly, intuitive and one stop shop for all our L&D activity. Longer term this platform will enable us to host learning differently using digital learning methods such as videos, self-directed learning and pod casts and move us towards the creation of a learning culture.

We also have launched our new joint on-line appraisal process which includes regular one-to-one meetings. This gives staff dedicated space to have meaningful conversations about their health & well-being, their role, career progression, and gain any support needed. The on-line system is a move away from paper, and feedback from our people has been very positive.

RD&E is a full provider of apprenticeships, which means we benefit from the same status as an educational provider. Apprenticeships are a key strategic enabler which support in-recruitment activity and the creation of new roles, retention and development activity of our own staff. We offer apprenticeships for both clinical and non-clinical roles from level 2 through to a level 7. Being a full provider allows us to deliver apprenticeships to both our internal staff but also offer apprenticeship places externally. In 2021 we launched our People Development Academy where we now offer accredited CMI management/leadership apprenticeship qualifications both internally to our own staff, and also to the wider ICS system. Delegates are benefited from working with colleagues from across the wider health and social care system, as well as gaining a qualification.

COVID continued to challenge how we delivered learning, and we responded by making many of our people development activities accessible virtually, in bite-size and/or a combination of methods so development continued but would not impact on workforce numbers that can treat patients.

We also launched our new Management Development Support Package. This was a specifically tailored package in response to the COVID crisis, which aims to give immediate support to managers and their teams. This has been invaluable during a very challenging time, and helped individuals with practical coping strategies.

As COVID pressure start to reduce, we have refreshed all of our Development Programme activity, and also developed career ladders for various staffing groups within the Trust. This helps individuals to see how they can progress, supports us in growing our own staff and thus improves the retention of our people.

Health Education England (HEE) Continuous Professional Development (CPD) funds have been fully utilised in the Trusts. This has ensured that development opportunities have been maximised by our registered workforce in their clinical skills, non-clinical skills and leadership/management confidence/capability.

The Trust was one of the first NHS Trusts mentioned by Gatsby to have launched our T-level qualifications, increasing the attractiveness of careers in healthcare amongst the younger generations.

Counter fraud and corruption

The Trust is committed to countering fraud and corruption and achieves this by working with the ASW Assurance Counter Fraud Team, and by raising awareness of fraud through both the internal intranet (Hub) and presentations delivered to staff at both divisional and speciality level.

The Trust has a number of policies to guide and support staff, such as the Standards of Business Conduct and the Trust's Whistleblowing Policy. Staff access Trust policies via the HUB, and are encouraged to seek clarification direct from the policy author, or through the Head of Governance.

The ASW Assurance Counter Fraud Team monitor and report fraud to the Board through the Audit Committee.

Expenditure on consultancy

The total expenditure on consultancy for the 2021-22 financial year was £714,000 compared to £1,402,000 in 2020/21.

Trade Union facility time

The Trust is proud of its work with its Trades Unions, and works in collaboration with their representatives throughout the Trust. Our Partnership Forum is the formal group where our staff side and management representatives formally engage and consult.

As part of the Trade Union (Facilities Time Publication Requirements) Regulations 2017, the Trust is required to report facility time, which is paid time-off during working hours for trade union representatives to carry out trade union duties.

The 2021 report provided to the Cabinet Office is reflective of the period 1 April 2020 to 31 March 2021.

(https://www.gov.uk/government/statistical-data-sets/public-sector-trade-union-facility-time-data)

Number of Trade Union representatives

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
34	28.1

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	10
1-50%	20
51-99%	3
100%	1

Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£101,964
Trust's total pay bill	£316,945,000
Percentage of the total pay bill spent on facility time	0.03%

Paid Trade Union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	13.78%

NHS Staff Survey

Our approach to staff engagement and key activities

Our staff work together to achieve the best and safest outcomes for people who require acute and community care and working with communities and other stakeholders to keep people well and supported at home. While staff at the RD&E share a common purpose, there is a great deal of diversity in the roles and functions staff perform – it is the effective blending of all that enables the RD&E to have great teams working in the best interests of the people we are here to serve, our patients and the public.

Staff engagement helps to:

- deliver continued improvements and programmes of change-engaged staff are likely to exert more influence over the use of standard processes, teamwork and the degree to which there is a culture of improvement.
- connect clinicians with the organisation as well as the professional agenda and take on leadership roles.
- improve sickness absence.

The Trust has developed a multi-year programme focused on improving staff engagement as part of a broader organisational development and culture change agenda. Based on overwhelming academic evidence that demonstrates a clear link between committed and motivated staff, improved patient outcomes and patient experience, the Trust has consciously sought to build a culture in which staff engagement is viewed as mission critical. Our approach to staff engagement focuses on:

- creating the conditions for optimum staff engagement
- assisting people to prepare for and actively participate in changes to care
- contributing to improved patient care now and in the future
- ensuring engagement efforts are as inclusive as possible

Having staff that are informed and have access to the information they require to do their jobs is important. However, there are a range of factors including reward, values and behaviours, recognition and leadership as well as giving staff "voice" and influence over their work through greater empowerment.

Our methodology is one that encompasses the whole organisation and is based on the understanding that all staff have a level of responsibility to consider and act on staff engagement and that engagement is a two-way process. It is essential to enable staff to develop the necessary skills and behaviours required to manage the scale of change required to deliver health and care differently into the future, and we need to support them to do that. We aim to deliver more joined-up care for people out of hospital and this will only be realised if the culture and outlook of staff right across the organisation rapidly adapts. Our staff are at the heart of these changes as we lead the way in helping to innovate and transform services, to ensure that our way of delivering care and services is fit for the future.

Our approach to engagement aims to create optimum conditions for job satisfaction, with a particular focus on outcomes in the following areas, so that our staff feel:

1. Valued: Nurture a culture of gratitude and appreciation and implement mechanisms for recognition and award, raising awareness/flagging issues that undermine this
2. Listened to: Promote two-way dialogue between staff and management and implement tools, activities and training to facilitate active listening and outcomes and amplify staff "voice"
3. Connected: Generate a welcoming and inclusive work environment in which staff feel a genuine sense of belonging, involving people in a meaningful set of values and behaviours and inspiring them with a clear and compelling strategic narrative
4. Employees are informed: Staff receive open, honest and timely information through a range of appropriate channels to enable them to go about their work fully engaged and motivated.
5. Empower employees to drive positive change: Cultivate an environment in which staff are trusted and supported to play an active role in continuous improvement and changes to care.
6. Employee wellbeing: Assist efforts to ensure colleagues feel supported and well in their work and personal life

As the above environment and culture is generated, the RD&E's reputation as a good employer is enhanced, consequently improving staff retention and better, safer care.

A range of regular mechanisms are in place to monitor and learn from staff feedback, including:

- NHS Staff Survey: The Trust has continued to engage each division and larger departments in developing and implementing bespoke, local action plans in response to the evidence collated from the staff survey, and these are made available for all colleagues to view and share best practice via the Trust intranet, Hub.
- People Pulse survey: the new, quarterly regional People Pulse launched in July includes 15 staff engagement related questions. A dashboard is being developed to enhance reporting.
- Learning from Excellence: staff can easily submit reports which celebrate excellence, enabling us to create new opportunities for learning and improving resilience and staff morale.
- Monthly all-staff webinar: Staff are able to anonymously ask questions ahead of the webinar and in real time, which are then answered by three of our Executive and Trust Directors. A recording and FAQ is made available afterwards.

In addition to these regular mechanisms, we have also monitored and learnt from staff feedback to develop a range of staff improvements, such as staff rest spaces, travel to work options, and staff catering. Due to the significance of our integration with NDHT, over the last year, a range of engagement mechanisms have been put in place to monitor and learn from staff feedback, including:

- Meetings and focus groups about the new organisation's mission, objectives and values.
- TUPE webinars with our Executive Directors, followed by separate sessions with Staffside representatives, where staff could ask questions about TUPE.
- "Staff Say" meetings, which provided a safe environment for staff to openly discuss issues and anonymously raise issues with senior management.
- A survey which supported us to develop the name of our integrated organisation.
- A cultural assessment survey to support us to explore what our culture is and what we'd like it to be in the future.
- Focus groups and a survey with staff to help us develop a new staff intranet.

Indicator score and benchmarking scores

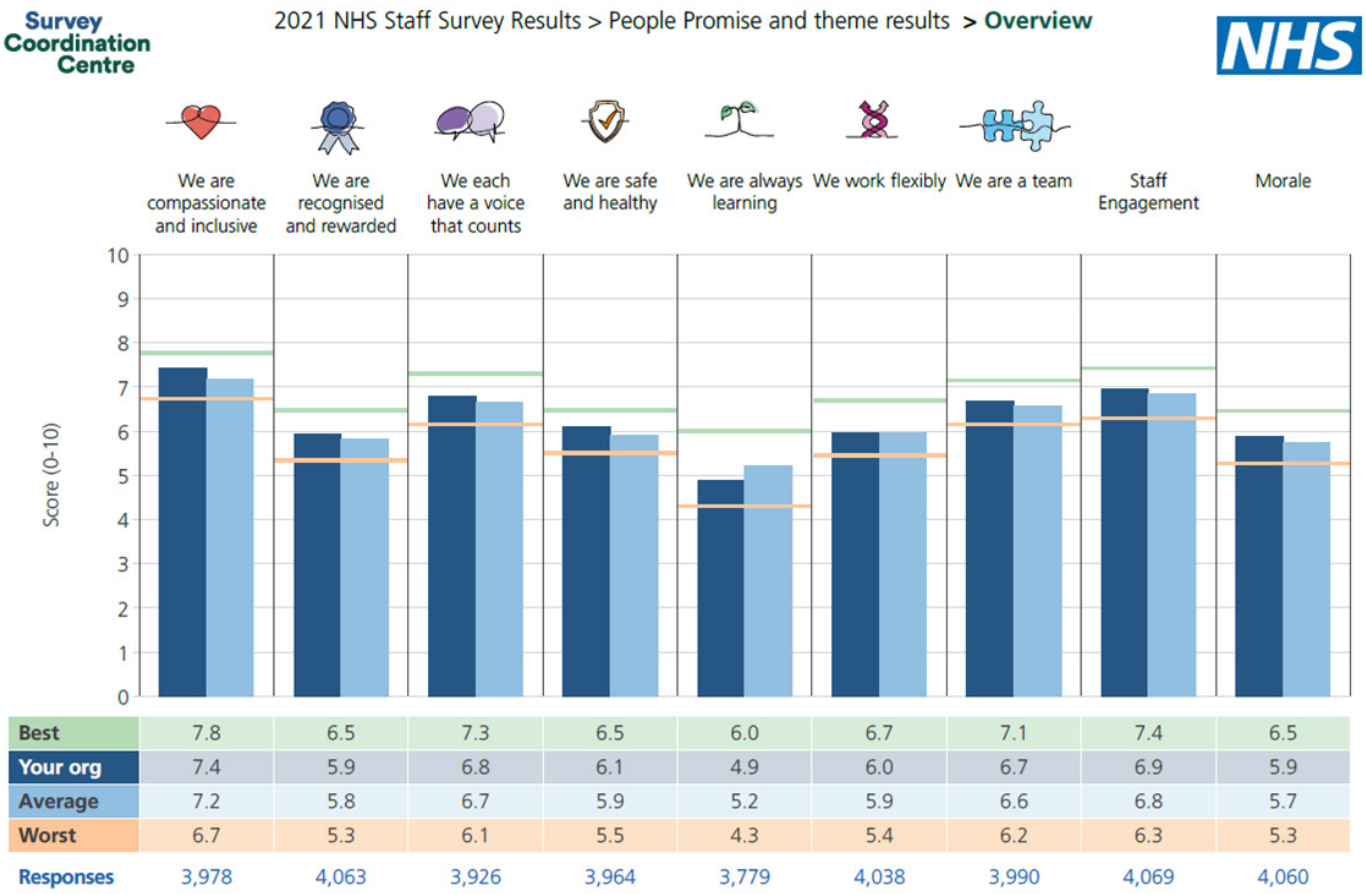
The NHS staff survey is conducted annually. From 2018 to 2020, the results from questions are grouped to give scores in ten indicators. 2021 saw the most significant changes to the NHS Staff Survey within the last decade, as the survey has been aligned to the seven People Promise elements, though it still maintains the two existing Staff Engagement and Morale themes. Sub-scores have been introduced within the element/theme scores, providing greater depth of insight. The indicator scores are based on a score out of 10 for certain questions, with the indicator score being the average of those.

The response rate to the 2021/22 NHS Staff Survey among trust staff was 46 % (2020/21: 44 %).

	2020/21	2021/22		Trust improvement /deterioration
Response rate	RD&E	RD&E	Combined Acute & Community Trusts	
	44%	46%	46%	2% increase

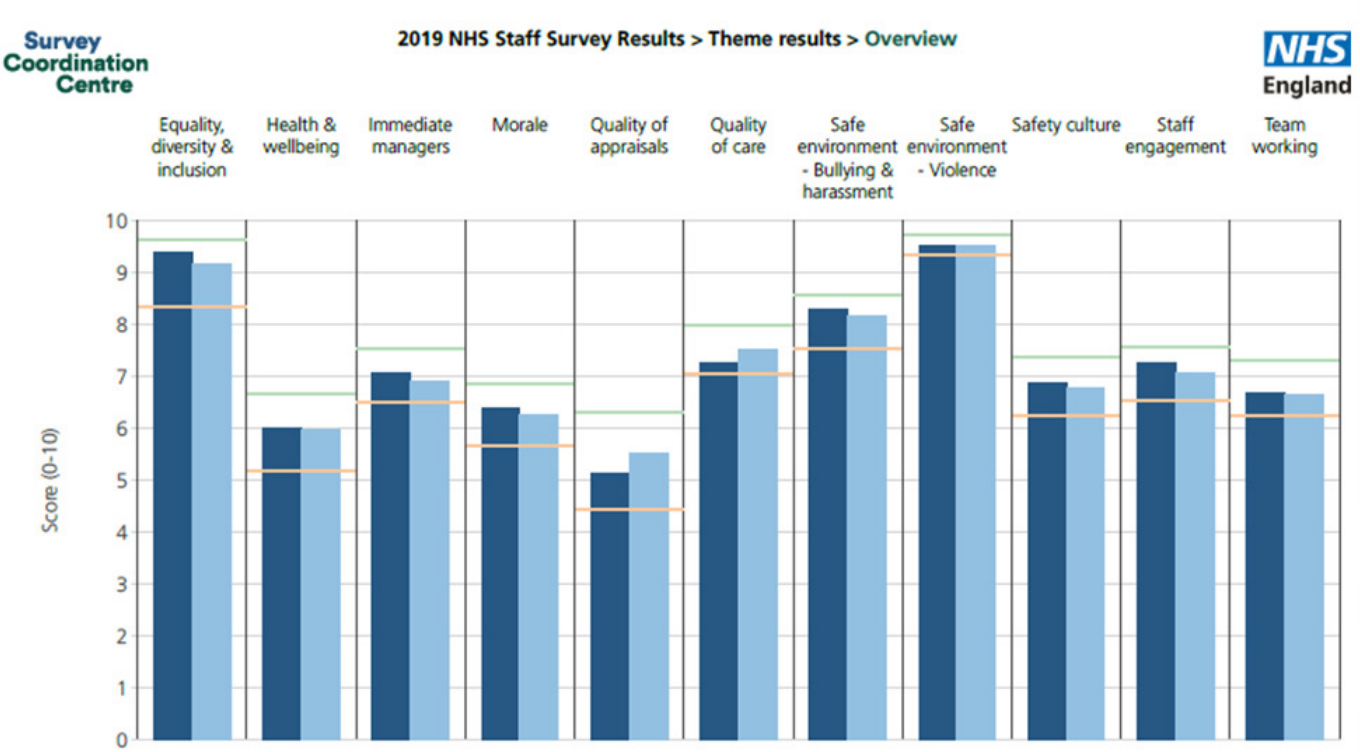
For 2021, the third wave of COVID-19 struck while the survey campaign was running (with severe staff shortages due to illness and isolation), the mass vaccination programme was and the integration with NDHT may have impacted response rates. Despite this, the Trust saw an increase in the response rate by two percent from the previous year.

Scores for each indicator together with that of the survey benchmarking group (combined acute and acute community) are presented below and in the associated table below.

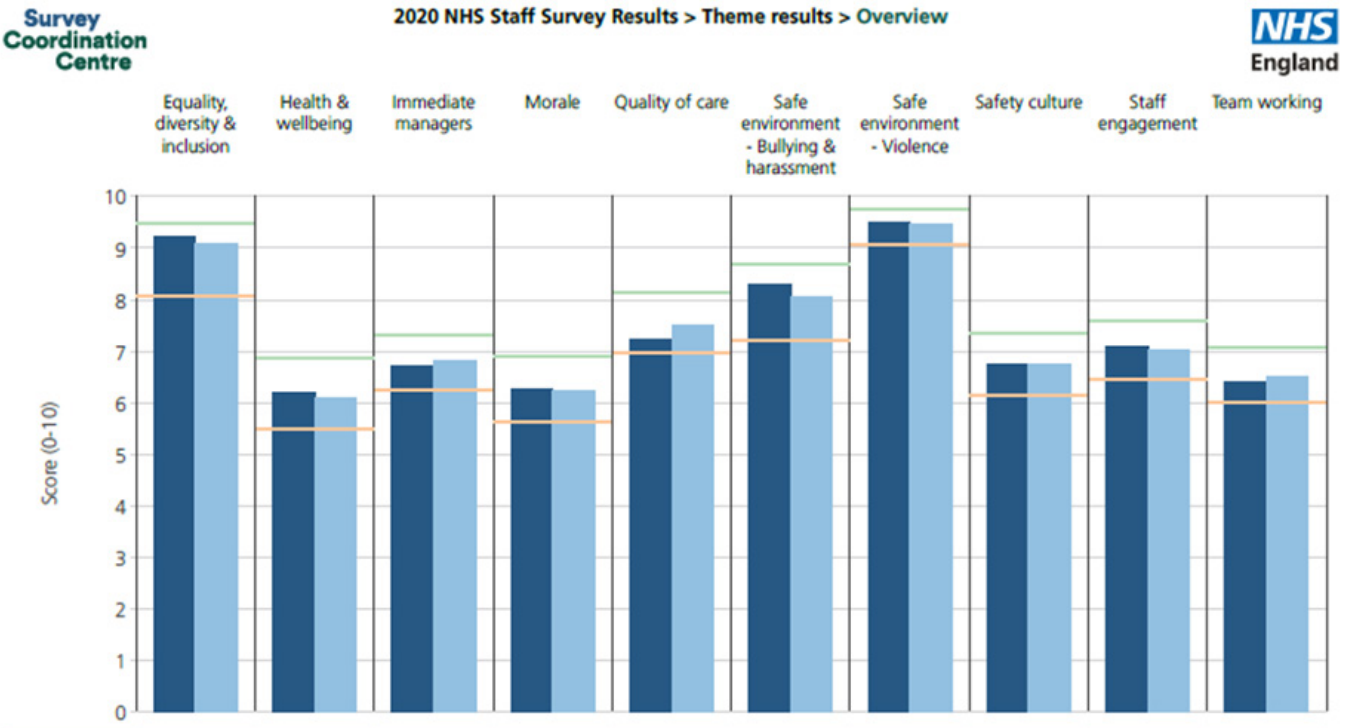


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.8	6.1	4.9	6.0	6.7	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,978	4,063	3,926	3,964	3,779	4,038	3,990	4,069	4,060

The below two tables show the scores and the change in survey components for the indicator scores for 2019 and 2020.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.5	6.8	6.3	8.0	8.6	9.7	7.4	7.6	7.3
Your org	9.4	6.0	7.1	6.4	5.1	7.3	8.3	9.5	6.9	7.3	6.7
Average	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7
Worst	8.3	5.2	6.5	5.7	4.4	7.1	7.5	9.3	6.2	6.5	6.2
Responses	981	983	981	963	772	872	976	977	975	990	975



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.2	6.2	6.7	6.3	7.2	8.3	9.5	6.7	7.1	6.4
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,816	3,842	3,850	3,792	3,385	3,721	3,826	3,803	3,887	3,852

Action plans

For 2020/21, the RD&E Staff Survey action plans sat at divisional level, with updates going to Divisional Performance Assurance Framework (PAF) reviews with Divisions leads and Executive Directors. In addition, team managers with 11+ respondents to the survey were encouraged to complete an Action Plan, in response to the survey findings. In total the Trust has received 48 Action Plans from across the Trust for 2020/21.

Trust wide, a Morale Programme was formed in 2021 and chaired by the Chief People Officer to action developments following the 2020/21 staff survey and other channels, to deliver rapid interventions for staff morale and wellbeing. The programme has prioritised a large estates project refurbishing staff rest rooms, managers' guidance for promoting wellbeing, reviewing and directing charitable funds towards interventions boosting staff morale (festive season celebrations and appreciation), and supported holding a trust wide staff awards celebration, which adheres to COVID safe guidance.

Key findings

In terms of staff sentiment against four key indicators the Trust has continued to perform well and is rated above average by our people. However, the scores have declined from previous years, as displayed below:

The overall 'NHS staff engagement' indicator is assessed by combining the answers to nine key questions from the NHS Staff Survey. The RD&E score was 6.9 (out of 10) comparing to 6.8 nationally for similar Trusts; combined acute and acute & community Trusts.

As highlighted, 2021 saw the most significant changes to the NHS Staff Survey. From the nine key indicator areas, staff scored the Trust above the national average in eight of the nine areas:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff Engagement theme
- Staff Morale theme

While the survey highlights key achievements it also identifies areas that have room for improvement, with the following identified as key improvement areas (subject to Board approval and Task and Finish Team prioritisation):

- We are always learning: four questions relating to appraisals scored lower than average.
- Flexible working opportunities
- Staffing level at Trust the most declined score (this follows a national trend)
- Pockets of the Trust with low engagement scores

Staff sentiment indicator	Acute and Community Trusts 2021 average	**RD&E outcome 2021**	RD&E outcome 2020
Staff recommending the organisation as a place to work (Q18c)	58%	**65%**	71%
Staff recommending that if a friend or relative needed treatment would be happy with the standard of care provided (Q18d)	67%	**78%**	84%
Staff feeling care of patients/service users is organisations top priority Q18a)	75%	**80%**	83%
Staff think the organisation acts on concerns raised by patients/ users (Q18b)	71%	**72%**	75%

Summary of results: selected indicators

	2021/22		2020/21		2019/20	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Morale	5.9	5.7	6.3	6.2	6.4	6.5
Staff engagement	6.9	6.7	7.1	7.0	7.3	7.1
We are compassionate and inclusive	7.4	7.2	N/a	N/a	N/a	N/a
We are recognised and rewarded	5.9	5.8	N/a	N/a	N/a	N/a

	2021/22		2020/21		2019/20	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
We each have a voice that counts	6.8	6.7	N/a	N/a	N/a	N/a
We are safe and healthy	6.1	5.9	N/a	N/a	N/a	N/a
We are always learning	4.9	5.2	N/a	N/a	N/a	N/a
We work flexibly	6.0	5.9	N/a	N/a	N/a	N/a
We are a team	5.9	5.7	N/a	N/a	N/a	N/a

Future priorities and targets

Due to delays with the lifting of the embargo for the 2021 NHS Staff Survey, the Trust is currently reviewing the findings and recent results from the quarterly People Pulse.

The 2022 plan includes developing a response by a Staff Survey Task and Finish Team, with an equivalent team for the former NDHT. The teams have representatives from across the Trust, including managers, staff side, staff governors, staff group representatives and the Engagement/Staff Experience Team.:

- Learning and development opportunities and appraisals
- Staffing – colleagues less able to meet all the conflicting demands, not enough staff
- Flexible working opportunities
- Compassionate culture-teams meet less regularly to discuss effectiveness and 'staff report feeling less able to make improvements happen in their area of work'
- Continue the successful delivery of the health and wellbeing programme, now with a new Health and Wellbeing Committee and a separate Stakeholder Working Group
- Continue to support remedial work for staff groups, divisions and departments with low staff engagement scores – focus of localised engagement plans
- Continue to deliver decisively, such as through the Morale Programme Group or Health and Wellbeing Groups on basic needs, raised by staff (could include physical environment; staff rooms, queues in canteen, outdoor space for staff to take breaks)
- Continue to communicate the Trust's plans and actions around travel/parking provision
- Launch our new Values and Behaviours
- Our newly appointed Lead Freedom to Speak Up Guardian will work closely with our Human Resource team to improve the culture, specifically supporting and encourage staff to Speaking Up (for more information regarding The Freedom to Speak Up Service, please see page x of the Quality Account)

A trust-wide action plan will be established from the work on the Staff Survey Task and Finish Team to address key areas of concern/priorities identified by the two task and finish groups (formerly RD&E & NDHT). The plans will be monitored through committees such as People, Workforce Planning & Wellbeing Committee (PWPW), Staff Partnership Forum (with HR & Staffside representatives), and the Board of Directors.

Divisions and larger departments will be requested to refresh their localised Action Plans, taking them through the PAF.

The Trust will continue to improve on staff experience, with the aim of maintaining our position to score above the national average as measured by the engagement score in the NHS Staff Survey and other feedback mechanisms.

Off payroll payments

Table 1:

Number of new engagements, or those that reached 6 months duration between 1 April 2021 and 31 March 2022, for more than £245 per day and that lasted longer than 6 months	0
of Which	
Number assessed as within IR35	0
Numbers assessed not as within the scope of IR35	0
Number engaged directly (via PSC contracted to a Trust) and are on the Trust payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 2:

Number of new engagements, or those that reached 6 months duration between 1 April 2020 and 31 March 2021, for more than £245 per day and that lasted longer than 6 months	0
of Which	0
Number assessed as within IR35	0
Numbers assessed not as within the scope of IR35	0
Number engaged directly (via PSC contracted to a Trust) and are on the Trust payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

There were no off-payroll engagements of a board member with significant financial responsibility during the financial year.

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 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 financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

In any cases where individuals are included within the first row of this table the trust should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

Board Assurance Framework (BAF)

The BAF is a Board-owned document whose primary role is to inform the Board about the totality of risks or obstacles that may impede it from achieving its strategic objectives, as outlined in the Trust's long-term strategy document. The BAF also provides assurances that adequate controls are operating to reduce these risks to acceptable levels. Over the past two years the BAF has been on an evolutionary journey, in parallel with the redevelopment of the wider governance arrangements within the Trust. The BAF is explained further in the Annual Governance Statement on pages 116 to 128.

Audit Committee

The Audit Committee is a formal, statutory committee of the Board of Directors. From August 2021, as part of the closer working arrangements with NDHT, the Audit Committee became a Joint Audit Committee for the RD&E and NDHT, with Chairmanship rotating between Mr Alastair Matthews (an RD&E Non-Executive Director with a financial background) and Kevin Orford (NDHT Non-Executive Director, also with a financial background).

Whilst there is still a requirement for organisation specific issues to be dealt with for 2021/22, processes and reporting have been aligned where possible. This has been made easier due to the RD&E and NDHT having the same Internal and External Auditors, as well as a shared Counter Fraud function.

The primary role of the Joint Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system.

Six Non-Executive Directors constitute the membership of the Joint Audit Committee (three from each Board) from August 2021. Five Non-Executive Directors constituted membership of the RD&E Audit Committee prior to the Joint Audit Committee.

The Joint Audit Committee is also attended by representatives of KPMG LLP, the Trust's External Auditors; Internal Audit, Counter Fraud Service, the Chief Operating Officer, Chief Financial Officer, Site Directors of Operational Finance, and the Director of Governance.

As part of the external audit plan for 2021/22, KPMG highlighted three significant audit opinion risks and other audit risks relating to IFRS16, which have been considered by the Audit Committee.

Valuation of land and buildings

The Trust's accounting policies require a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. Where assets are subject to significant volatility, annual revaluations may be required. Conversely, where changes in asset values are insignificant then a revaluation may be necessary only every 3 or 5 years.

A full valuation of land and buildings was last carried out by a commercial valuer for the Trust in 2019/20.

For 2020/21 and 2021/22 an assessment of the change in building indices has been undertaken, and a report was taken to the February Joint Audit Committee setting out that assessment.

Over the past two years the index has been fairly changeable, with the index rising and falling throughout this period. The fluctuation is mainly due to the effect that the pandemic has had on the global economy and how this has affected the price of building supplies. Over the two years the report set out that the building index is forecast to have increased by 6.27% at March 2022. Applying this increase to the net book value of buildings and dwellings, the increase is below the audit materiality threshold, and therefore no revaluation adjustment has been made in the accounts for 2021/22, other than an impairment relating to the Nightingale Hospital of £9.8m.

In 2021/22 the Nightingale Hospital site has been repurposed to provide greater theatre and diagnostics capacity, with a further investment of circa £16.2m being made. The investment relates to changes to the internal configuration of the building and the purchase of new equipment. Costs that have been incurred relating to internal changes to the buildings' structure may have led to an impairment charge to the previous valuation. An external valuer was appointed to undertake a valuation of the site.

KPMG have not identified any issues arising from the work performed relating to the revaluation of land and buildings.

Fraud risk from expenditure recognition

Auditing standards suggest for public sector entities a rebuttable assumption that there is a risk expenditure is recognised inappropriately. We considered this risk to be most likely to occur through manipulating accruals at the end of the year to bring forward expenditure. KPMG will carry out a number of procedures in order to respond to the significant risk identified.

KPMG have not identified any issues arising from the work performed relating to expenditure recognition.

Management override of controls

Professional standards require KPMG to communicate the fraud risk from management override of controls as significant. Management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

KPMG have carried out appropriate controls and substantive procedures, testing and substantive procedures, including testing of journal entries, accounting estimates and significant transactions that are outside the normal course of business, or are otherwise unusual. No specific instances of management override were identified from this audit.

IFRS 16 implementation

The delayed adoption of IFRS16 has been confirmed as taking place from 1st April 2022. Whilst the full implementation will not be required in the 2021/22 financial statements, the impact of the new standard will be required to be reported in a note to the financial statements. KPMG have identified a number of potential audit risks relating to IFRS 16 and have set out how they intend to test these risks.

At the February 2022 Joint Audit Committee, a report was received which set out the impact of the new IFRS 16 standard.

Under the standard, most leases will now be recorded on the statement of financial position (SOFP) rather than being expensed through the I&E account.

In line with the Trust's capitalisation policy, all leases that have a value greater than £5k and a with a lease term longer than 12 months will now be recorded on the SOFP position as liabilities, along with an asset reflecting the right to use the asset over the lease term. The lease payments will no longer be expensed in the I&E over the lease term, instead the asset will be depreciated over the life of the lease and an interest charge will also be charged to revenue expenditure.

A lease register has been created by the RDE that includes details for each lease and calculates the financial effect of adopting the new standard.

From the work carried out, it is forecast that the value of the Trust's assets will increase by £55.5m, with an equivalent lease liability being created.

KPMG have not identified any issues arising from the work performed relating to the IFRS 16.

Other issues considered by the Audit Committee

Review of standing financial instructions and scheme of delegation

In preparation for the merger of the RD&E and NDHT, the Joint Audit Committee reviewed a proposal to consolidate the existing RD&E and NDHT SFI's and SoD. These documents are designed to help ensure that financial transactions are carried out in accordance with the law and government policy, as well as helping to ensure financial accuracy, economy, efficiency and effectiveness.

The proposal set out the key changes to the documents which were approved by the Joint Audit Committee and subsequently approved by the Trust Board of Directors.

Effectiveness of the external auditors

KPMG LLP were appointed as external auditors to the Trust from 2019/20 for a five-year period to 31st October 2024, under a competitive tender process.

In addition to the procurement tender exercise, the Joint Audit Committee annually assesses the effectiveness of the external auditors, in particular the timeliness of reporting, the quality of work and whether audit fees provided value for money. The Joint Audit Committee provided the Council of Governors (CoG) with positive feedback and assurance that the external auditors provided a quality, timely and cost-effective external audit service.

The external auditors have not provided any non-audit services to the Trust in 2021/22.

Meeting schedule

The Audit Committee met six times during 2021/22. The names of members and their attendance at 2021/22 meetings are as follows:

NAME	Apr 2021	May 2021	June 2011	Aug 2021	Nov 2021	Feb 2022
A Matthews	P	P	P	P	P	P
K Orford*				P	P	P
P Dillon**	P	P	P			
S Kirby	P	P	P	P	A	P
Professor J Kay	P	A	P	A	P	A
P Geen*				P	P	P
T Neal*				P	P	P
Professor C Bones**	P	A				

*Mr Orford, Mrs Geen and Mr Neal joined the Joint Audit Committee in August as NDHT Non-Executive Directors

** Professor Bones resigned from the Committee in May 2021, Mr Dillon resigned from the Committee in June 2021 and Mrs Geen resigned from the Committee in March 2022.

P – Present
A – Apologies

Duties and Responsibilities of the Audit Committee

Governance, risk management and internal control

The Joint Audit Committee reviews the establishment and maintenance of an effective system of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives.

In particular, the Joint Audit Committee reviews:

- all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board
- the assurance processes that underpin the achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies and procedures for all work related to fraud and corruption as set out in the NHS England standard contract and as required by the NHS Counter Fraud Authority.
- The annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual report and Accounts.

In carrying out this work, the Joint Audit Committee primarily utilises the work of internal audit, local counter fraud specialists, external audit and other assurance functions, but is not limited to these functions. It will also seek reports and assurances from the Governance Committee, Directors and Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

The internal audit function is provided by ASW Assurance. The Joint Audit Committee ensures that there is an effective internal audit function, including the Counter Fraud function, established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Joint Audit Committee, Chief Executive and Board. This is achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the annual internal audit plan, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- consideration of the annual Head of Internal Audit's opinion
- follow-up by the Governance Committee, or one of its sub-committees, where internal audit's work is an area covered by that committee, as set out in internal audit's plan
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust, and
- an annual review of the effectiveness of internal audit.

External Audit

The Joint Audit Committee:

- reviews and monitors the external auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
- keeps under review the level of non-audit services provided by the external auditor, taking into account relevant guidance
- makes recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and
- approves the remuneration and terms of engagement of the external auditor

Further, the Joint Audit Committee reviews the work and findings of the external auditor and considers the implications of, and management's responses to, their work.

This is achieved by:

- discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in their annual plan
- discussion with the external auditors of their evaluation of audit risks and associated impact on the audit fee, and
- reviewing all external audit reports together with the appropriateness of management responses

Other Functions

The Joint Audit Committee considers the work of other committees within the Trust, the work of which can provide relevant assurance to the Joint Audit Committee's own scope of work. This particularly includes the Joint Governance Committee because of its management of the Trust's Corporate Risk Register and the Clinical Audit function.

The Joint Audit Committee also:

- reviews material changes to standing orders and standing financial instructions and schemes of delegation
- receives a report from management on the review of data quality included in the Quality Report and
- is given the opportunity, where possible, to review the accountancy element of any significant financial transaction within the Trust prior to its presentation to the Board of Directors for approval.
- receives a Statement of Losses and Compensation once a year which has been approved by the Chief Financial Officer

Financial Reporting

The Joint Audit Committee reviews and, if thought appropriate, recommends to the Board approval of the annual report and financial statements, focusing particularly on:

- specific enquiry into the question of whether the Trust keeps proper books of account
- the integrity of the financial statements
- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas, and
- significant adjustments resulting from the audit
- the annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual Report and Accounts
- Providing assurance on behalf of the Board to the Department of Health around the costing process and methodology as required by the Reference cost guidance.

Board of Directors Reporting Arrangements

The Chairs of the Joint Audit Committee provide a report highlighting the key issues arising from the Joint Audit Committee to the meeting of the Board that directly follows the Joint Audit Committee. The minutes of the Joint Audit Committee are also available to the Board.

The Annual Governance Statement, which is included in the Annual Report, reviews in considerable detail the effectiveness of the system of internal control. By concurring with this statement and recommending its adoption to the Board, the Joint Audit Committee also gives the Board its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

NHS System Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for identifying where Integrated Care Systems (ICS) and NHS organisations may benefit from, or require support, to meet the standards required of them in a sustainable way, and to deliver the overall objectives of the sector in line with the priorities set out in 2021/22 Operational Planning Guidance, the NHS long Term Plan and the NHS People Plan. Alongside local strategic priorities, and a single set of metrics that are reviewed across ICS, and their constituent member organisations, the framework looks the following national themes:

- quality of care
- access and outcomes
- preventing ill health and reducing inequalities
- people
- finance and use of resources
- leadership and capability

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy.

Segmentation

The current assessment for the RD&E is segment 3 (Providers offered mandated support). This is as a result of concerns in relation to performance, specifically elective and cancer, as well as issues in relation to patient flow in and out of hospital.

This segmentation information is correct as at 24 March 2022.

Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is registered in full without conditions.

The Trust underwent a planned, routine, announced Care Quality Commission Inspection in January and February 2019, the report was published on 30 April 2019. The Trust was rated overall "Good".

The inspection identified 13 "Must Take" actions and 76 "Should Take" actions. The Governance Committee monitor progress of the action plans through to completion.

Below is a breakdown of the ratings for the Trust.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Are resources used productively?	**Good**
Combined rating for quality and use of resources	**Good**

Rating for Acute Services/Acute Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Devon and Exeter Hospital (Wonford)	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019
Honiton Hospital	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Mardon Neuro-rehabilitation Centre	Good ↑ Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Overall trust	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Community Health

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community health inpatient services	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community end of life care	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Urgent Care	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall*	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for primary medical services

Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Castle Place Practice	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Ratings for Royal Devon & Exeter (Wonford)

Ratings for Royal Devon and Exeter Hospital (Wonford)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016
Medical care (including older people's care)	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Surgery	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Critical care	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Maternity	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Services for children and young people	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019
Renal	Good Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019
Overall*	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Trust underwent a routine Inspection as part of the CQC's Winter Inspection Programme on the 19th January 2021 on the Trust's Infection, Prevention and Control arrangements.

The inspection report noted the following:

- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.
- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for both patients and staff.
- Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns without fear.
- It was evident from speaking with staff that the challenges caused by the pandemic were both physically and mentally challenging, but they remained passionate about providing quality care to their patients.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

- All staff were committed to continually learning and improving services. There were systems and processes for learning, continuous improvement, and innovation. Leaders and staff also collaborated with partner organisations to help improve services for patients.

The report outlined two actions that the Trust should take to improve further:

- The Trust should continue to monitor compliance with appropriate levels of personal protective equipment, including enhanced personal protective equipment to ensure its use is in line with national guidance. The trust should improve those areas of infection prevention and control practice which are not currently being followed in line with national guidance.
- The Trust should consider ways in which it can further promote staff and patient engagement with compliance with cleaning of shared use equipment.

These actions form part of the ongoing IPC action plan which will be monitored through to completion by ICDAG and the Clinical Reference Group, who report into the Governance Committee.

Due to the targeted focus of the inspection, the overall rating of the Trust and Royal Devon & Exeter Hospital does not change and remains 'Good' in both cases.

Signed:

Suzanne Tracey
Chief Executive Officer
Date: 08 June 2022

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of the Royal Devon & Exeter 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 Officers Memorandum issued by Monitor (NHSI).

Under the NHS Act 2006, Monitor (NHSI) has directed the Royal Devon & Exeter NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Royal Devon & Exeter NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 have been followed, and
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- 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

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 him/her 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.

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

Signed:

Suzanne Tracey
Chief Executive Officer
Date: 08 June 2022

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst 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 the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable 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 the RD&E, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the RD&E for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a comprehensive governance system in place which has been developed and enhanced over a number of years and continues to be subject to regular review to ensure its continued fitness for purpose. The current governance architecture was established in October 2011. A number of independent reviews have been undertaken over the years which have concluded that the governance system is robust.

During phase one of the COVID-19 pandemic, the Trust temporarily adjusted its governance system with the Board of Directors approving a "Governance Lite" approach. The main changes were the pausing of some Committees and Sub Groups of the Governance Committee, with the direct reporting of essential groups such as Health and Safety and the Incident Review Group and Divisional governance risks and gaps in assurance to the Governance Committee. A review of the Trust's Governance Lite arrangements was undertaken by Internal Audit in October 2020 which reported that "overall the Trust has designed and operated sound governance arrangements as approved by the Board of Directors during the COVID-19 pandemic. The Trust has returned fully to its pre-COVID Governance Performance System.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. ASW Assurance (internal audit) and KPMG (external auditors) attend all Audit Committee meetings. The Audit Committee receives all reports of the Internal and External Auditors and reports regularly to the Board.

Risk issues are reported through the Governance Committee via the Safety and Risk Committee and the Trust's management structure. Management of risk is delegated to the appropriate level from Director through to local management through the Divisional management teams. There are established Governance Managers in post to support the Divisions in implementing robust risk and governance processes. Each Division has a Divisional Governance Group which meets regularly to manage risk and report and escalate concerns via the five sub committees of the Governance Committee. Performance management of any governance/risk action plan is managed via the Trust's Performance Assessment Framework (PAF) led by the Chief Operating Officer. Strategic risks are managed via the Board-owned Board Assurance Framework (BAF). This document focuses on risks that could prevent the Trust from achieving its strategic objectives.

The Board has appointed a Senior Independent Director to be available to Governors and Members if they have concerns where contact through the normal channels of Chairman, Chief Executive Officer or Deputy Chief Executive, have failed to resolve them or for which such contact is inappropriate. In addition, the Trust has a Whistleblowing Policy to guide and protect staff who raise issues of concern. The Trust also has four Freedom to Speak Up Guardians who report (via the Director of Governance) to the Chief Executive Officer and provide regular reports to the Governance Committee.

All staff joining the Trust are required to attend Corporate Induction which covers key elements of risk management. This is further enhanced at departmental induction. Training courses are run on a regular basis and provide staff with the skills needed to undertake risk management duties. Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. Risk management is included in the Trust's mandatory training programme and follow-up refresher training; the Trust's risk management policies and procedures are available on the Trust's intranet.

An electronic governance system (Datix), which has the ability to record, manage and triangulate incidents, complaints, risks and legal claims has been operational since June 2011.

An established cohort of senior clinical staff and Governance Managers trained to conduct Serious Incidents Requiring Investigation (SIRI) is in place and additional staff are trained each year to add to the pool available. The Risk Management Team co-ordinates SIRIs and adverse incidents, which are reported and managed through the Incident Review Group (a sub group of the Safety and Risk Committee). In addition to direct feedback to relevant clinical teams, Lessons Learned briefings, highlighting learning points, are made available to all staff via the local intranet. All SIRI investigation reports and action plans are shared with the Trust's lead commissioner; NHS Devon CCG.

The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust. It reviews the Board Assurance Framework ("BAF") quarterly in line with the Trust's Risk Management Policy. The BAF identifies the key risks and mitigations related to the Trust's strategic objectives and key priorities. The Board has identified a number of financial risks to the achievement of the corporate strategy including the Trust's ability to deliver the required cost savings, and the impact of financial pressure on performance targets.

In order to further align the Governance Performance Systems across both Trusts (RD&E and NDHT) in preparedness for the proposed merger of the two organisations in April 2022, Board, Audit and Governance meetings have been held jointly over the last year (whilst still maintaining their legal and statutory requirements).

The Corporate Risk Register is reviewed by the Joint Governance Committee at every other meeting (three times per year). The Joint Governance Committee reports to the Board of Directors quarterly. The Joint Audit Committee considers the Board Assurance Framework and the Corporate Risk Register when setting Internal Audit's annual work plan.

The Director of Governance attends both the Joint Governance Committee and the Joint Audit Committee. This supports continuity and oversight of agenda preparation and completion of actions. The Chairs of the Joint Governance Committee are also members of the Joint Audit Committee, ensuring the two Committees are aligned and there are not gaps in assurance.

The Board of Directors, as part of the Annual Plan reporting cycle, is responsible for the completion of the Corporate Governance Statement. The Board has adopted a process by which evidence is identified for each element of the statement to provide assurance and support a decision of compliance or gap in compliance (i.e. risk). Where risk is identified this would be risk assessed, mitigating actions put in place and added to the appropriate risk register.

The Joint Governance Committee is chaired jointly by two Non-Executive Directors (one from each Trust) and provides oversight of the risk management process. The Committee takes a comprehensive oversight of the quality and safety of care provided by the Trust and provides assurance to the Board of Directors. The work of the Joint Governance Committee is supported by four key sub committees:

- Clinical Effectiveness Committee – chaired by the site Medical Director
- Joint Integrated Safeguarding Committee – chaired by the Chief Nursing Officer
- Joint Safety and Risk Committee – chaired by the Chief Executive Officer
- Joint People, Workforce Planning and Wellbeing Committee – chaired by the Chief People Officer

These four Committees are responsible for monitoring and managing specific types of risk.

The Joint Safety and Risk Committee, chaired by the Chief Executive Officer, has a number of key sub-groups leading the Trust's management of safety and risk:

- The Patient Safety Group is accountable for delivery of the Trust's patient safety programme and is chaired by the Director of Nursing. The Mortality Review Group is chaired by Dr Daly

- The Incident Review Group is chaired by the Director of Nursing and reviews all Serious Incidents Requiring Investigation (SIRI) and action plans
- Radiation Safety Group is chaired by one of the Associate Medical Directors
- Infection Control and Decontamination Group is chaired by the Joint Directors of Infection Prevention and Control
- Joint Health and Safety Group is chaired by the Chief People Officer
- Emergency Preparedness, Resilience and Response Group is chaired by the Chief Operating Officer
- Medical Devices Group is chaired by the Medical Director
- Information Governance Steering Group is chaired by the Caldicott Guardian

Other specialist groups whose work relates closely to safety and risk report via the Clinical Effectiveness Committee include the Medicines Management Group.

The Patient Experience Committee was paused in 2020 during COVID for a review and refresh. During this time patient experience has continued to be managed centrally by the Patient Experience Team, through the Divisional structure and through the newly established site Patient Experience operational group which is chaired by the Site Director of Nursing. Performance information has continued to be available to the Board of Directors (RD&E) / Trust Board (NDDH) through the monthly Integrated Performance Report. Patient stories have continued to be a standard agenda item for the Board of Directors / Trust Board; these stories, which are video recordings of patients sharing first hand their experiences have provided an invaluable connection for the Board to our patients. Selection of the stories is undertaken with the independent support of the comms team ensuring a balance of both "what has gone well" and "even better if". In all cases learning is identified and where relevant appropriate actions put in place.

As part of the review and refresh, a Patient Experience Strategy has been developed, which at the time of writing is currently undergoing a consultation and engagement process. The final version of the strategy will be shared with the Board of Directors for approval later this year. Contained within the strategy is the re-introduction of the Patient Experience Committee which will be chaired by a Non-Executive Director.

The Trust has a robust, responsive and reflective reporting and monitoring framework in place in relation to Mortality and Learning from Deaths.

All deaths that occur in the Acute Trust and Community Hospitals are reviewed within 24 working hours by a Medical Examiner, in line with the National Medical Examiner System. This system is responsible for ensuring accuracy of death certification, referral of cases as appropriate to Her Majesty's Coroner, and identification and escalation of governance issues to the Trust and Mortality service. Cases are identified for specialist review in line with National Guidance, and those that fulfil the CQC Duty of Candour regulations (Section 20) identified. Themes identified from this comprehensive review are presented monthly to the Mortality Review Group which reports into the Safety and Risk Committee.

The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are used within the organisation to monitor trends in data quality and mortality. A detailed Trust level mortality dashboard is scrutinised by the Mortality and Review Group on a monthly basis. Mortality is reported to the Board of Directors monthly through the Integrated Performance Report and quarterly through the Joint Governance Committee by a detailed Learning from Deaths Report. The Board also receives relevant mortality reports by escalation from the Governance Committee. The Trust sets a low threshold in relation to responding to deviations in mortality rates, with deep dive case note reviews undertaken to ensure that the causes of any deviation(s) can be identified and acted upon, where required. In the last financial year, this additional scrutiny has focussed on deaths following COVID-19 diagnosis.

The Trust is actively working to ensure the recommendations made as part of the NHSI Learning from Deaths Review are being implemented and embedded in practice. This is overseen by the Trust's Governance Committee.

The Chief Nursing Officer and Chief Medical Officer have joint Director leadership and accountability for Clinical Governance. To ensure Executive Directors are aware of all safety issues in a timely manner and to utilise their expertise, Safety Huddles are in place. The Safety Huddle comprises of the Chief Nursing Officer, Chief Medical Officer, the Site Director of Nursing, the Site Medical Director, the Assistant Director for Safety and Quality and the Risk Manager. The huddle takes place once a week and complements the formal Governance Performance System by looking at soft intelligence but also provides an opportunity to discuss incidents/concerns in real time at a senior level.

Risk identification and evaluation

The Trust has a Risk Management Policy which has been approved by the Joint Governance Committee and clearly sets out the process for identifying and managing risk and the Trust's risk appetite. It incorporates a standard methodology in which risk is evaluated using a likelihood/consequence matrix. The roles and responsibilities of staff in managing risk are defined and key posts highlighted. The Policy also includes the governance reporting structure and the terms of reference of the Joint Governance Committee and all the committees reporting to the Joint Governance Committee.

The Trust maintains a comprehensive Corporate Risk Register covering both clinical and organisational risk.

There are 33 current risks on the Corporate Risk Register. There are 16 risks with scores of 15 and above:

- One related to capacity management
- One related to achieving cancer waiting time targets
- Five related to demand and capacity on individual services i.e. emergency department, ophthalmology, medical imaging, cardiology and heart failure.
- Five related to workforce i.e. medical, nursing, and estates and facilities
- Two related to mental health pathways (external factors)
- Two related to COVID-19, i.e. infection control measures and the disruption to diagnostic/ treatment pathways as a result of the COVID-19 pandemic. A further four risks related to COVID-19 also sit on the CRR with scores of between 12 and 8.

Robust action plans are in place and these risks are assigned to an appropriate Executive lead and manager who are responsible for ensuring that the risk is either eliminated or managed appropriately. A robust system is in place to monitor progress of action plans, which is undertaken by both the Director of Governance and the Manager of the risk to ensure that risks are proactively managed down to their end target score. A detailed report is produced by the Director of Governance to the Joint Safety and Risk and Joint Governance Committees on a predefined frequency.

The Trust has Divisional level risk registers which feed into the Corporate Risk Register. At Divisional level, the risk registers contain lower level localised risks which can be managed by the relevant Division. The Corporate Risk Register contains the high-level risks and Trust-wide risks. This ensures that risks are identified, managed and escalated appropriately at all levels of the organisation. Risk assessments, including Health and Safety and Infection Control, are undertaken throughout the Trust. All areas of the hospital have trained Risk Management Officers, and the Risk Management Department and Director of Governance facilitate Risk Surgeries to provide support and training and to ensure consistency in approach.

The Trust has a robust process for assessing risk to cost improvement plans (CIP). A Quality Impact Assessment is undertaken which includes identification of risk, risk score and mitigating actions. The assessment is reviewed and if appropriate authorised by the Divisional triumvirate (Divisional Director, Associate Medical Director and Assistant Director of Nursing). Quality Impact Assessments with a risk score of 8 or above are reviewed by the Chief Nursing Officer and Chief Medical Officer, with the Trust's Operations Board overseeing the total process.

Other sources used to identify risks include:

- Complaints, Care Quality Commission and Health Service Ombudsman reports and recommendations
- Inquest findings and reports from HM Coroner
- Health and Safety Executive and regulatory body compliance inspections
- Medico-legal claims and litigation reports
- Reviews commissioned from external bodies i.e. Royal Colleges
- Health Scrutiny Committee reports
- Incident reports and trend analysis (via Datix software, identification of hot spots)
- Internal and external audit reports
- Performance Assurance Framework
- Feedback from Governors and Members
- Ward to Board Framework, Care Quality Assessment Tool

The Trust has systems and processes in place to assess whether there is sufficient suitably qualified competent staff to meet the treatment needs of our patients safely and effectively. The Trust benchmarks staffing and effectiveness against the model hospital data with both staffing establishments and safe staffing data being reviewed and monitored by the Board in the integrated performance report on a monthly basis.

The Demand and Capacity planning undertaken to inform the Trust operational plan identifies the broad workforce priorities and involves full clinical engagement with robust exploration of assumptions and appropriate challenge. The Trust is aiming however to improve its longer-term workforce planning approach and is currently identifying its preferred model to support this work. The Trust's People Strategy encompasses a comprehensive implementation plan to address the workforce challenges for the future.

The Trust uses an e-rostering system for nurses, midwives and care staff. The Allocate Safe Care tool is used to undertake a census three times a day to assess the acuity and care hours per patient day; Staffing tactical meetings happen daily. As a minimum, an establishment and skill mix review is undertaken annually for each clinical area. The Trust has also introduced Medirota for Medical staff. Medical staff are also included in the tactical meetings at times of extreme pressure and during critical incidents with redeployment of medical staff where appropriate.

The reviews use relevant national guidance as set out and also detail clinical judgement, triangulated with safety metrics and patient outcomes to safe and effective skill mix.

Where service changes are identified, such as a reduction of beds due to staffing shortfalls specifically in community hospital settings, they are always supported by a quality impact assessment.

The Performance Assurance Framework also use metrics including staffing and safety measures to assess the effectiveness and safety of care.

The People, Workforce Planning and Wellbeing Committee is well established and transacts all core governance business in relation to staff. The Committee has been held jointly with NDHT and has a workplan including a cycle of reporting, metrics and dashboards to provide assurance around the quality and capacity of services within our People Function. Regular safe staffing reports are also received to the Committee as well as Guardian of Safe Working Hours reports for Consultants. The Committee also receives strategic updates relating to staff and ensures an oversight of risks within the people function and wider workforce risks across the Trust.

The Committee has sub-groups for People Development and Staff Wellbeing and also receives updates from the Trust Partnership Forum meetings, with staffside forming part of the quoracy of the Committee, to enable appropriate levels of challenge and transparency. The Committee reports directly to the Governance Committee providing a clear route of escalation through to the Board.

Recruitment and Retention remains a priority for the Trust and indeed the wider NHS. In the past year, the recruitment market has become more competitive than ever before. The NHS has released a number of national initiatives in recent years relating to workforce, namely the NHS People Plan, the NHS health and wellbeing framework and the HR & OD review. The Trust has been heavily engaged with these programmes to ensure that everything possible is being done to recruit and retain our people.

The Board review the Integrated Performance Report (IPR) each month, including a core section containing key metrics and information about 'Our People', to ensure that staffing establishment, turnover, sickness etc. are all reviewed and monitored by the Trust.

This year the People Function have undergone a restructure in the senior team, in order to be able to deliver services more effectively across the RD&E and NDHT, but also to ensure appropriate resourcing levels in specialist areas such as Workforce Planning. Having dedicated resource in place will support the Trusts to implement a suitable model to ensure a longer-term workforce planning approach and to build longer term plans from the current workforce annual establishment reviews and demand and capacity planning processes.

The Trust believes the above is in line with the 'Developing Workforce Safeguards[1]' recommendations on using evidence-based tools, professional judgement and outcomes to ensure safe staffing processes exist and are in line with the National Quality Board guidance[2].

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance.

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.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK

Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

[1] Developing-workforce-safeguards.pdf (england.nhs.uk)
[2] 2904770 NQB Guidance v1_2_with links A (england.nhs.uk)

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

At the start of the pandemic the NHS funding regime was temporarily changed to allow all Trusts to achieve breakeven to ensure adequate resources were available to enable timely response to the funding decisions needed. However, the non-recurrent nature of the additional funding did not resolve the underlying deficit faced by the Trust as the cost base growth was in excess of the recurrent income that the Trust would earn in normal circumstances.

During the 2021/22 financial year the finance regime changed in line with the national settlement for the NHS, reducing income levels over the second half of the year, moving the Trust into a deficit position. Whilst the change in funding led to a level of uncertainty on the national funding frame work regular briefings have been presented to board to understand the impact on the Trust's in-year financial position but more importantly tracking the underlying financial position.

As we start to more to a more business as usual funding regime and see the income levels for the Devon ICS move towards a target allocation level over time, the impact on the Trust will continue to be forecast to support the longer-term recovery needed to bring stability to the financial position. The focus will be on productivity to ensure that recovery of elective waiting lists can be prioritised whilst ensuring sound cost control to avoid worsening the underlying deficit.

Overall in year performance is monitored via an integrated performance report at the monthly meetings of the Board of Directors. Operational management and the coordination of Trust services are delivered by the Executive Directors. Performance of individual clinical Divisions is monitored formally on a monthly basis through the Performance Assurance Framework which is led by the Chief Operating Officer and twice annually with all Executive Directors.

An element of assurance provided to the Board is the rigidity of the financial control processes. Internal audit review the overall financial controls to support the head of internal audit opinion and the Trust continues to be rated at a significant level of assurance int his area.

I can confirm that the Trust complies with the cost allocation of and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

As well as key financial controls, Internal Audit has conducted reviews on health and safety, serious incident reviews, payroll, Care Quality Commission regulations, GDPR compliance, data quality, the Ockendon response and CNST maternity standards, as well as areas of operational process. In addition, they have annual reviews of the Trust's risk management and governance arrangements.

Information governance

Information governance and data security is managed by the Information Governance Steering Group, led by the Caldicott Guardian. The Chief Medical Officer is the Trust's nominated Senior Information Risk Owner and Freedom of Information Lead. Information Asset Owners for critical systems have been identified; system risk assessments and Information Risk Management training is undertaken annually.

An Information Security Forum, chaired by the Deputy Chief Information Officer, deals with all aspects of information security and data confidentiality. Risks to information security are reported directly to the Information Security Forum (a sub group of the Information Governance Steering Group) and recorded on the Corporate Risk Register.

The Trust has completed the Data Protection and Security Toolkit assessment and the Safety and Risk Committee and the Board of Directors has received a report regarding its system for control of Information Governance.

On 29 June 2021 the Trust published the annual Data Security and Protection Toolkit assessment, which had been delayed by NHS Digital due to COVID-19. The return included 105 out of 109 mandatory evidence items and 36 of the 40 assertions. The Trust completed three of the four remaining evidence items in December 2021, with one outstanding item delayed by COVID-19, and is currently rated as "Approaching Standards" by NHS Digital.

The 2021/2022 annual Data Security and Protection Toolkit assessment has now been moved to a completion date of 30 June 2022.The initial baseline was published on 28 February 2022, with a second baseline publication on 4 March 2022 to evidence current cyber security compliance. Work is progressing for full submission in June 2022.

During 2021/22 the Trust reported seven Information Governance incidents to the Information Commissioners Office in line with the reporting requirements. An incident involved research information that had not been appropriately anonymised due to the rarity of the health issue involved making the patient potentially identifiable. An incident where a drug form was given to the wrong patient. An incident involving a technical issue in the electronic patient record resulting in letters being sent to patient's previous addresses. An incident involving staff data published within a job advertisement and three incidents relating to inappropriate access of medical records by staff.

The Information Commissioner has responded to six of these incidents and we are awaiting their outcome in response to the seventh. The ICO has considered taking further action against an individual for inappropriate access in one incident. The other five incidents, the ICO stated "No Further Action by the ICO", with the recommendation to investigate the causes of the incidents to ensure we understand how and why they occurred and what steps we need to take to prevent them from happening again. The incidents were fully investigated by the Trust with mitigating actions put in place, including the recommendations from the Information Commissioner.

The Trust actively promotes the importance of good Data Quality throughout the Trust to ensure accuracy, completeness and timeliness and the risks associated with any inaccuracies.

NHS England guidance and embedded legislation on the recording and monitoring of Elective Waiting Time data is complex and allows for local agreement and flexibility in how some rules are interpreted. To ensure that inherent risks and unintended consequences from local interpretation are monitored, the Trust has a robust framework and meeting structure that supports and drives the Information Governance agenda. This provides the Board of Directors, via the Joint Safety and Risk Committee, with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

Assessment of Data Quality incorporating Referral To Treatment/Elective Waiting List Management is included in the Trust's annual Internal Audit work plan. The audit process provides independent assurance of the design and operation of controls in place.

The Trust's Access policy establishes a number of principles and definitions and defines roles and responsibilities to assist with the effective management of waiting lists relating to outpatient appointments, elective treatment imaging and other diagnostic tests. Furthermore, standard operating procedures are in place to support staff in applying a consistent and effective approach to Waiting List Management.

Detailed operational monitoring occurs across all specialties and in conjunction with internal metrics against data quality. These are applied to identify areas for improvement and are monitored on a regular basis.

Annual Quality Account

The Trust has produced a Quality Account which will be submitted with the Annual Report in June 2022. Following guidance provided by NHSE/I there is no requirement for the Quality Account to be externally assured.

The Trust has established systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, Divisional and Trust levels. In line with the Trust's commitment to openness and transparency, the data included is not just limited to good performance and is publicly reported at least on a quarterly basis. The Joint Audit Committee undertake a review of the data assurance underpinning the Quality Report and through this process and other review of data, the Board of Directors are assured that the Quality Account represents a balanced view.

Internal Audit have a three year audit cycle to assess quality systems and data (similar to that in place for our financial systems), was agreed with our internal auditors and built into the Internal Audit plans for future years. This will be an on-going process and the Board of Directors will use the recommendations from this work to further improve the robustness of the process underpinning the Quality Report. The most recent review of Data Quality was undertaken in February/March 2022 and the result was limited assurance, with a number of management actions agreed.

The next annual review will be undertaken during 2022/23.

Audit of mandated indicators

Following guidance provided by NHSE/I the Trust is not required to undertake an audit of mandated indicators.

COVID-19

The Trust initiated its pandemic plans in line with national guidance on 4 March 2020. The Local Resilience Forum (LRF) declared an LRF Major Incident on 16 March 2020 and an Incident (Gold) Management Team was established which has met every day since. The Incident Management Framework of Gold (which has a number of hubs and groups within its structure) sits alongside the Trust's existing Governance Performance System as outlined above.

During wave 1 the Trust and indeed the wider South West were not impacted by COVID-19 in the same way as other Trusts have been throughout the country as the disease prevalence and profile has been much lower than predicted. We believe that the lock down arrangements put in place by the Government had a significantly positive impact for the region. This has allowed the Trust time to plan and prepare and put in arrangements, such as the hosting of the Devon and Cornwall Nightingale Hospital, in readiness for a second surge. The Nightingale Hospital was opened in November 2020 and discharged its last patients in February 2021. In early 2022 the Nightingale remained a system asset, but had a change of use to an Orthopaedic day surgery unit and outpatient facility for Ophthalmology and Rheumatology.

As already detailed, as part of the Trust's planning and preparedness and as a direct result of COVID-19, the Trust reviewed its Governance arrangements, taking a "Governance Lite" approach. The four Sub Committees of the Governance Committee were revised and where appropriate replaced to provide a flatter structure. Some sub groups and Divisional Governance groups paused, but were replaced with direct access into the Governance Committee via Executive Leads. The new arrangements were approved by the Board of Directors (and shared with the Trust's Internal Auditors) in May 2020 for an initial period of three months. The effectiveness and outcome of Internal Audit's review concluded in October 2020. The Board of Directors concluded that Governance Lite had served the Trust well and approved a return to the previous governance performance system. The focus on Governance did not change during COVID-19 with patient and staff safety remaining the highest priority for the Board of Directors. The Trust returned fully to its pre-COVID-19 Governance Performance System and has maintained this throughout 2021/22.

Review of effectiveness

As Accountable 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 trust who 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, the Joint Audit Committee and Joint Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes applied in maintaining and reviewing the effectiveness of the system of controls includes:

- The maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on corporate risk
- Review of the Board Assurance Framework and receipt of Internal and External Audit reports to the Audit Committee
- Personal input into the controls and risk management processes from all Executive Directors, Senior Managers and clinicians

- The review of the Trust's risk and internal control framework is supported by the annual Head of Internal Audit opinion which states significant assurance can be given, that there is a sound system of internal control and that the controls are generally being applied.
- Evidence gathering for core Care Quality Commission regulations and registration.
- Self-assessment against the Care Quality Commission's Essential Standards for Quality and Safety (reviewed by Internal Audit)
- Self-assessment against NHSI's Code of Compliance and NHSI's Governance Framework
- Performance monitoring by the Board of Directors of the Trust's strategy and operational milestones to achieve internal and external targets
- Results of the national patient and staff survey results and development of targeted action plans
- Delivery of the Health and Safety action plan
- The Trust's compliance with the Hygiene code
- The Trust's unconditional registration with the CQC, rated overall as 'Good' March 2019
- Safe Staffing reviews

My review of the effectiveness of the system of internal control has been presented and approved by the Board of Directors. The Board of Directors and the Joint Audit and Joint Governance Committees have been kept informed of progress against action plans throughout the year.

Conclusion

There are no significant internal control issues I wish to report in respect of 2021/22.

Signed:

Suzanne Tracey
Chief Executive Officer
Date: 08 June 2022

Directors report

The RD&E is an NHS Foundation Trust that is constituted as a public benefit corporation. Its governance structure is founded on a constitution that is approved by the regulator, NHSI. The constitution sets out how the organisation will operate from a governance perspective and what arrangements it has in place, including its Committee structures and procedures, to enable the Trust to be governed effectively and within the legislative framework. The Trust's constitution incorporates the legal and statutory requirements necessary to govern the Trust. In addition, Monitor (NHSI) has developed a Code of Governance which all Foundation Trusts must comply with (or explain if they choose not to comply). This details the necessary governance structures and processes that Foundation Trusts should have in place.

Essentially, there are three basic components to the RD&E's governance structure:

- The Membership
- The CoG
- The Board of Directors

Members of the RD&E consist of members of the general public who choose to apply for membership and Trust staff (unless they opt out). Members are located in a defined number of constituencies.

Members elect Governors and can stand for election themselves.

The CoG consists of elected public Governors, staff Governors and appointed individuals from key stakeholder organisations (as defined in the constitution). Governors help bind the Trust to its patients, service users, staff and stakeholders. Governors are unpaid and volunteer part-time on behalf of the Trust. They are not Directors and therefore do not act in a directional capacity as their role is very different. The Trust Chairman is chair of both CoG and the Board of Directors.

Governors are the direct representatives of local communities. They collectively challenge the Board of Directors and hold them to account for the Trust's performance, as well as presenting the interests of Foundation Trust Members and the public and providing them with information on the Trust's performance and forward plan. Governors have a range of statutory powers as well as significant influence over the Trust; they appoint the Chair and the Non-Executive Directors and ratify the appointment of the Chief Executive.

The Board of Directors of the RD&E is ultimately and collectively responsible for all aspects of the performance of the Trust. The Board of Directors' role is to:

- Provide effective and proactive leadership of the Trust within a framework of processes
- Take responsibility for making sure the Trust complies with its Licence, its constitution, mandatory guidance issued by NHSI, relevant statutory requirements and contractual obligations
- Set the Trust's vision, values and standards of conduct and ensure the Trust meets its obligation to its members, patients and other stakeholders and communicates them to these people clearly
- Set the Trust's strategic aims at least annually, taking into consideration the views of the CoG
- Be responsible for ensuring the quality and safety of healthcare service, education, Training and research delivered by the Trust
- Ensure that the Trust exercises its functions effectively, efficiently and economically
- Develop procedures and controls which enable risk to be assessed and managed
- Take decisions objectively in the interests of the Trust
- Take joint responsibility for every decision of the Board, regardless of their individual skills or status
- Share accountability as a unitary Board
- Constructively challenge the decisions of the Board and help develop proposals on priorities, risk, mitigation, values, standards and strategy.

The Board of Directors has both Executive and Non-Executive Directors (NEDs). All Non-Executive Directors are independent. It is a unitary Board which means that both Executive and Non-executive Directors share the same liabilities and joint responsibility for every decision of the Board. In so doing, Board members bear full legal liability for the operational and financial performance of the Trust. The Chief Executive is the nominated Accounting Officer and is responsible for the overall organisation, management and staffing of the NHS Foundation Trust, for its procedures in financial and other matters, and for offering appropriate advice to the Board on all matters of financial propriety and regularity.

In carrying out their role, Directors need to be able to deliver focused strategic leadership and effective scrutiny of the Trust's operations, and make decisions objectively and in the interest of the Trust. The Board of Directors will act in strict accordance with the accepted standards of behaviour in public life, which include the principles of selflessness, openness, honesty and leadership (The Nolan Principles).

The Board of Directors is legally accountable for services provided by the Trust and is responsible for setting the strategic direction, having taken account of the views of the CoG, and of the overall management of the RD&E.

The Board is led by the Non-Executive Chairman. In addition, there are seven Non-Executive Directors who, together with the Chairman, form a majority on the Board. The Executive Directors manage the day-to-day operational and financial performance of the Trust.

The Board normally meets to conduct its core business at least ten times a year. At these meetings it takes strategic decisions and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements.

Board meetings

The Board's meeting schedule for 2021/22 was returned to normal with no Board meetings cancelled or postponed. Due to ongoing COVID-19 challenges and following the guidance issued by NSHE/I all meetings were held using MS Teams virtual technology.

As part of the preparations for the proposed merger with Northern Devon Hospital Trust and to support the ongoing alignment of governance processes between the two Trusts, Joint Board meetings were held from April 2022.

The papers for the monthly Public Board meeting and the approved minutes of the previous meeting are published on the Trust's website in advance of the Board meeting. In advance of the legislation compelling NHS Foundation Trusts to hold their Board meetings in public, the RD&E decided in June 2012, to move to public Board meetings that were accessible to the public. These are meetings that take place in the public arena rather than public meetings, although members of the public have the opportunity to ask questions at the end of the public section of the meeting. Items of a confidential nature are discussed by the Board in private in a monthly confidential meeting. The issues discussed in the closed sessions tend to be commercial in-confidence issues that may impede the conduct of the Trust's business if they were to be aired publicly. The 1960 Act on Admission to public Meetings is used by the Board to help determine which topics are discussed privately and, over the course of the year, the Board has sought to discuss the majority of its business in the public session. In addition to its formal Board meetings, the Board also holds a number of development and strategy sessions.

The framework within which decisions affecting the work of the Trust are made are set out in the Trust's published Standing Orders, Standing Financial Instructions and Scheme of Delegation, copies of which may be viewed on the Trust's website (www.rdehospital.nhs.uk) or on request from the Foundation Trust Secretary.

The composition of the Board is in accordance with the Trust's Constitution and the Policy for the Composition of NEDs on the Board. The Board considers it is appropriately composed in order to fulfil is statutory and constitutional function and remain within the NHSI's Licence. In consultation with Governors, it has, through its recruitment of NEDs, been able to maintain a good quality and effective Board that is appropriately balanced and complete.

There is a clear division of responsibility between the Chairman and the Chief Executive. The Chairman heads the Board, providing leadership and ensuring its effectiveness in all aspects of its role, and sets the Board agenda. The Chairman ensures the Board receives appropriate information to ensure that Board members can exercise their responsibilities and make well-grounded decisions. The Chief Executive is responsible for running all operational aspects of the Trust's business, assisted by the team of Executive Directors.

The Chairman and all Non-Executive Directors meet the independence criteria laid down in Monitor's/ NHSI's Code of Governance (Provision A.3.1). The Board is satisfied that no direct conflicts of interest exist for any member of the Board. There is a full disclosure of all Directors' interest in the Register of Directors' Interest which is available on the Trust's website or upon request from eh Foundation Trust Secretary. Directors and Governors may appoint advisors to provide additional expertise on particular subjects if required.

The Board of Directors is accountable to the membership via the CoG. The Chairman informs the CoG about the work and effectiveness of the Board at each Council meeting.

The Business of the Trust is conducted in an open manner and annual schedules of meetings for the Board of Directors and CoG are published 12 months in advance.

Board focus

Over the year the RD&E Board has led and governed the organisation successfully. Its focus has been on ensuring a sustainable and safe clinical service. A clear governance and management system is in place. The Board reviews in detail the Trust's safety, quality, financial and operational performance at every Board Meeting.

Some of the key issues the Board focused on during the year included discussions and debates on:

- the Trust's response to the COVID-19 pandemic, staff health and wellbeing and the Devon Mass Vaccination Programme
- operational Performance both COVID-19 and non-COVID-19
- reset and recovery after COVID-19
- outpatient transformation programme including commissioning of the Nightingale hospital and discussion of the governance arrangements
- Devon Integrated Care System (ICS)
- NHS and Devon System Long Term Plan including the road map for delivery
- NHS People Plan and local and ICS updates
- Quality Improvement Academy update
- South West Genomic Medicines Alliance presentation
- Green Plan
- proposed integration with NDHT
- collaborative working in South, East, North Devon (SEND)
- the MY CARE Programme
- Board Assurance Framework
- workforce including safe staffing reports, partnership working and the staff voice, gender pay gap and equality and diversity in the workforce
- responding to and Learning from Deaths quarterly reports
- Guardian of Safe Working Hours quarterly reports
- regular reports from the Audit and Governance Committees
- inclusion
- research and development
- infection prevention and control
- staff and patient survey results
- Ockenden Maternity Report
- patient stories
- The Board met as the Corporate Trustee

Outside Interests

The Board regularly updates is Register of Directors' Interests to ensure that each member discloses details of company directorships or other material interest in companies which may conflict with their management responsibilities. Board members also have an opportunity at the start of each meeting to declare any interests which might impede their ability to take part in discussions and Directors are aware that such a declaration would be permissible at any time during a meeting, dependent on the issue being discussed and the potential for any conflict to arise. The Directors' Register of Interests is available from the Foundation Trust Secretary (01392 404551) or on the Trust website:

https://www.rdehospital.nhs.uk/about-us/foundation-trust/foundation-trust-documents/
and Directors can be contacted via e-mail at:
rde-tr.foundationtrust@nhs.net

Board effectiveness and evaluation

The Board continued to develop its effectiveness during the year primarily through its programme of 'development days'. Development days are seminar sessions that allow the whole Board to explore a range of issues and topics and develop and discuss ideas outside the formal setting of the Board.

A total of eight Board Development Days were held during 2021/22 which focused on:

- Joint Development Days with the Board of NDHT, focussing on developing the roadmap for the joint clinical strategy, reviewing the vision statement, mission, strategic objectives and values and development of the corporate strategy.

- A joint Development Day with the CoG, focussing on the process for the development of the corporate strategy for the integrated trust and the vision for the new organisation.

The Chairman undertook appraisals for all NEDs. The process used a system that was co-designed and agreed by the Appraisals Working Group, a group made up of the Chairman, the Senior Independent Director and the Governors who sit on the Nominations Committee. The process involved a questionnaire aimed at the specific role of Board members that was used as part of a 360-degree feedback by fellow NEDs, Executive Directors and Governors.

Feedback on the performance of the NEDs was considered by the Chairman and fed back to the NEDs in appraisal meetings. Feedback on the performance appraisals was provided in written form and verbally to the Nominations Committee and an overview of the appraisals was discussed with the CoG. All the appraisals undertaken were favourable with all NEDs performing at or above the expected level. In the event of concerns being identified through the appraisal process, this would be managed in line with the appropriate Human Resource policy. A similar process was undertaken for the Chairman. In this case the process was led by the Senior Independent Director.

Feedback on the appraisals of the Executive Directors was provided by the Chief Executive to the Remuneration Committee (RC). The Chairman undertook an appraisal of the Chief Executive and the results of this were fed back to the RC.

Quality governance reporting

We have put in place a rigorous approach to governing the quality of our services. More details about these arrangements are included in the Annual Governance Statement (pages 116-128 of this report).

Well led

The Trust's approach to Well Led is outlined within the Accountability Report (from page 44) and also within the Annual Governance Statement (pages 116-128 of this report

The last independent review of the Trust's Well Led Framework was undertaken by the Care Quality Commission as part of a full routine inspection in January, 2019. The Trust received a 'Good' rating for Well Led and an overall rating of 'Good' for the full Inspection.

Foundation Trust code of governance

The RD&E has applied the principles of the NHS Foundation Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code.

Summary board attendance 2020/21

P = Public C = Confidential EC = Extraordinary Confidential	April 21		May 21		June 21		July 21		Aug 21	Sept 21		Oct 21	
	28th		26th		30th		28th			29th		27th	
	P	C	P	C	P	C	P	C		P	C	P	C
Mr J Brent	P	P	P	P	P	P	P	P		P	P	P	P
Prof C Bones	A	A	P	P									
Mrs C Burgoyne					P	P	P	P		P	P	P	P
Mr P Dillon	P	P	P	P	P	P	P	P		P	P	P	P
Mrs H Foster	P	P	P	P	P	P	P	P		P	P	P	P
Prof A Harris	P	P	P	P	A	A	P	P		P	P	P	P
Mrs A Hibbard	P	P	P	P	P	P	A	A		P	P	A	A
Prof J Kay	P	P	P	P	P	P	P	P		P	P	P	P
Prof H Khalil	P	P	A	A									
Prof B Kent					P	P	P	P		P	P	P	P
Mr S Kirby	P	P	P	P	P	P	A	A		P	P	P	P
Mr A Matthews	P	P	P	P	P	P	P	P		P	P	P	P
Mrs C Mills	A	A	P	P	A	A	P	P		P	P	P	P
Mr K Orford	P	P	P	P	P	P	P	P		A	A	P	P
Mr J Palmer	P	P	P	P	P	P	P	P		P	P	A	P
Mr C Tidman	P	P	P	P	P	P	P	P		P	P	P	P
Mrs S Tracey	P	P	P	P	P	P	P	P		P	P	P	P

P = Public C = Confidential EC = Extraordinary Confidential	Nov 21		Dec 21		Jan 22		Feb 22			Mar 22		
	24th		15th		26th		14th	23rd		22nd	30th	
	P	C	P	C	P	C	EC	P	C	EC	P	C
Mr J Brent	P	P		P	P	P	P	P	P	P	P	P
Prof C Bones												
Mrs C Burgoyne	P	P		P	P	P	P	P	P	P	P	P
Mr P Dillon	P	P		P	P	P	A	P	P	P	P	P
Mrs H Foster	P	P		P	P	P	P	P	P	P	P	P
Prof A Harris	P	P		P	P	P	P	A	A	P	P	P
Mrs A Hibbard	P	P		P	P	P	P	A	A	P	P	P
Prof J Kay	A	A		P	P	P	A	P	P	P	P	P
Prof B Kent	P	P		P	P	P	P	P	P	P	A	A
Prof H Khalil												
Mr S Kirby	P	P		P	P	P	P	A	A	P	P	P
Mr A Matthews	P	P		P	P	P	P	P	P	P	P	P
Mrs C Mills	P	P		A	P	P	P	P	P	P	P	P
Mr K Orford	P	P		P	P	P	P	P	P	P	P	P
Mr J Palmer	P	P		P	P	P	P	P	P	P	P	P
Mr C Tidman	P	P		P	P	P	P	P	P	P	P	P
Mrs S Tracey	P	P		P	P	P	P	P	P	P	P	P

From April 2021 meetings were Joint with NDHT Board

J Palmer joined in April 202, C Bones and H Kahlil left in May 2021, C Burgoyne and B Kent joined in June 2021

No formal Board meeting in August 2021

Board of Directors

Non-Executive Directors

James Brent, Chair

James joined the Trust in May 2012 and is both Chairman of the Board of Directors and CoG. He was an investment banker for twenty-five years and established Akkeron Group which has key business activities in hotels, urban regeneration and leisure. He is also Chairman of Hawksmoor Investment Management Limited, a private client investment and fund management group. He has combined his commercial ventures with a desire to contribute in a range of public sector settings as well, for example previously as Chairman of Plymouth City Development Company and of Plymouth University.

James was appointed as Chairman of NDHT

on 1 July 2018.

Chris Bones, Non-Executive Director (until 31 May 2021)

Chris joined the Trust in November 2019. He started his career in Human Resources and held senior roles reporting to the Board in both Diageo and Cadbury Schweppes.

He was appointed as Principal (later Executive Dean) of Henley Business School, publishing a book on the causes of the 2008 financial crash, which won the UK's Management Book of the Year Prize in 2012. He has held a number of non-executive roles in the public and private sector.

In 2011 he established an e-commerce consulting business in Exeter that has grown rapidly and now supports a number of leading brands from offices in Exeter, London and New York. He is a past Chair of the Trustee Board for the Terrence Higgins Trust and is the current Chair of the Chartered Institute of Legal Executives. Chris was a member of the Audit and Governance Committees. Chris was the Chair of the Patient Experience Committee.

Carole Burgoyne, Non-Executive Director (from 28 June 2021)

Carole joined the Trust in June 2021. She retired from Plymouth City Council in 2019 after 40 years of Local Government experience. She started her career as a Social Worker in Plymouth, became an Human Resources professional and ended as Strategic Director for People which covered the Statutory roles of Director of Children's Services and Adult Services. Carole has worked with partners in health to lead the transformation of social care in Plymouth and delivered a pioneering project to deliver the integration of commissioning with NEW Devon CCG and an integrated community health and social care services in Livewell Southwest. She worked in a range of senior leadership roles across the Council and led a wide range of services including Corporate Services, Refuse collection, Culture, Sport and Leisure, Community Safety and Housing as well as the Children's and Adults Services. Carole was awarded an MBE for services to children and young people in June 2017.

Married and living in Plymouth, Carole is a Trustee of Transforming Futures Multi Academy Trust and a Co-opted Governor of Thornbury Primary School.

Peter Dillon, Vice Chair

Peter joined the Trust in July 2013. After more than two decades at Deloitte and running his own financial advisory business, Peter is now Finance Director at The Rivers Trust, a national charity for education about and improvement of the UK's rivers. Until November 2015 Peter was also a Non-Executive Director in the Devon & Cornwall Housing Group, a social and affordable housing provider. Peter was previously chair of the Patient Experience Committee, Audit Committee and the Trust's Charity Sub-Committee, and until recently a member of the MY CARE Programme Board. Peter was appointed Vice Chair on 1 September 2018.

Janice Kay CBE, Senior Independent Director

Janice joined the Trust in April 2014. She is Provost of the University of Exeter and Deputy to the Vice Chancellor. She line manages the University of Exeter Medical School among other key roles. She holds a number of national positions in Higher Education, including the HEFCE Strategic Advisory Committee on Quality, Accountability and Regulation. Janice was appointed Senior Independent Director in April 2017.

Bridie Kent, Non-Executive Director (from 28 June 2021)

Bridie joined the Trust in June 2021. Bridie is a Registered Nurse, with a background in both clinical and academic appointments, resulting in extensive experience in leadership, quality improvement, practice change, health services education and implementation research. She has held a number of senior academic positions, including Head of school and Executive Dean at the University of Plymouth.

For the last 20 years, she has played a leading role in evidence-based practice uptake and implementation in the UK, New Zealand and Australia, working to enhance the transfer of evidence into practice, and improve quality of care for patients.

Hisham Khalil, Non-Executive Director (until 2 June 2021)

Hisham joined the Trust in November 2019. Hisham is the Head of the Peninsula Medical School, Faculty of Health, University of Plymouth. He is also a Consultant ENT Surgeon, University Hospitals Plymouth NHS Trust with an interest in Rhinology and Endoscopic Skull Base surgery. Hisham completed his surgical training in North Wales and the South West of England. He is a Non-Executive Director, University Hospitals Plymouth, NHS trust. and was the ENT South West Peninsula Clinical Research Network lead.

Hisham is a National Teaching Fellow and a Principal Fellow of the Advance Higher Education. He has a Doctorate Degree in Otolaryngology and is a Fellow of the Royal College of Physicians and Surgeons in Glasgow. He is also an External Assessor for the Irish Medical Council and a General Medical Council Associate. Hisham has been committed to the learning and teaching of undergraduate and postgraduate students and trainees in Medicine, Dentistry and Nursing. Outside medicine, Hisham has an interest in poetry and landscape photography. Hisham was a member of the Governance Committee and Chair of the Organ Donation Group.

Steve Kirby, Non-Executive Director

Steve joined the Trust in September 2017. Following a period in the NHS, he worked internationally in health, running hospitals before moving to consulting. As a Partner at KPMG and then Ernst & Young, he has consulted to a wide range of government and health organisations both in the UK and overseas. He has worked at all levels on a wide variety of health projects and programmes, including large system reorganisations, regulatory issues, and "at the coal face" helping to develop services or dealing with failing organisations. He was one of the two EY partners who undertook the administration of Mid Staffs NHS FT. Steve was appointed as Chair of the Governance Committee in September 2018 and is a member of the Audit Committee.

Alastair Matthews, Non-Executive Director

Alastair joined the Trust in October 2018. He has broad strategic financial and commercial experience gained in both the private and public sectors. He was Chief Financial Officer at the University of Plymouth for 5 years until November 2020. Prior to that he spent 8 years as Finance Director and Deputy CEO at the University of Southampton NHS Foundation Trust. He has been Finance Director at Ordnance Survey, including being a member of HMT's Financial Reporting Advisory Board, and spent 6 years as VP Finance and Administration at Computer Sciences Corporation.

He qualified and worked with Price Waterhouse in Bristol and then Southampton on a broad range of assignments across many sectors. Alastair is the Chair of the Trust's Audit Committee and Integration Programme Board.

Kevin Orford, Non-Executive Director

Kevin joined the RD&E Board on 29 March 2021. Kevin has a background in finance with previous roles as both an Executive Director and a Non-Executive Director in the NHS and as a Trustee on charity boards. He has previously served as a Non-Executive Member for Governance (Audit and Risk Committee Chair) for Southern Derbyshire Clinical Commissioning Group and was formerly Director of Finance and then Chief Executive of East Midlands Strategy Health Authority. He has a special interest in finance, governance and audit and their role in delivering high quality patient care.

Kevin is a Non-Executive Director of NDHT. He also serves on the Board of the Intellectual Property Office.

Executive Directors

Suzanne Tracey, Chief Executive Officer

Suzanne joined the NHS in 1993 having qualified as an accountant with Price Waterhouse. She held the post of Director of Finance/Deputy Chief Executive at Yeovil District Hospital NHS Foundation Trust since 2002 before joining the RD&E to take up the role of Director of Finance in 2008 and subsequently Deputy Chief Executive/Chief Financial Officer. Suzanne was appointed Chief Executive in 2016. She is also the Chair of the Healthcare Financial Management Association (HFMA) Provider Faculty and past President of the HFMA.

Suzanne was appointed as Chief Executive of NDHT on 18th June 2018.

Professor Adrian Harris, Chief Medical Officer

Adrian joined the NHS in 1981 and qualified from the Royal Free Hospital, University of London in 1986. He has been the Executive Medical Director since April 2015 and was appointed as Consultant Emergency Physician at the RD&E in February 1996. Prior to his appointment, Adrian served as Associate Medical Director for the Surgical Services Division and previously held the role of Director of the Emergency Department, spanning 12 years. Adrian has seen healthcare from both a primary and secondary care perspective, having trained as a GP before training in Emergency Medicine in 1990. He is an Honorary Associate Professor in Healthcare Leadership and Management at the University of Exeter Medical School.

In his spare time, Adrian is a practicing sports physician and is the Director of Sports Medicine for the Exeter Chiefs Rugby Football Club.

Adrian was appointed as Interim Medical Director at NDHT in June 2018 and as Executive Medical Director in December 2018.

Chris Tidman, Deputy Chief Executive Officer

Chris joined the Trust in September 2017, having worked in a number of senior NHS roles in the West Midlands across Acute, Mental Health and Commissioning sectors and as Director of Delivery and Improvement for NHSI. After graduating in 1991, Chris took his first CFO position in 2005 at South Birmingham Primary Care Trust before joining Birmingham and Solihull Mental Health Foundation Trust as Director of Resources and leading them to FT status in 2008. Chris joined Worcestershire Acute in 2011 as Director of Resources / Deputy CEO.

Chris has taken on strategic change projects, including major PFI hospital moves, EPR and IT change programmes, and developing strategic clinical partnerships with neighbouring providers. Chris has been part of the NHS Top Leaders programme and was also HFMA Chair for the West Midlands in 2015. Chris was appointed to the role of Deputy Chief Executive Officer in January 2021.

Hannah Foster, Chief People Officer

Hannah joined the Trust in August 2019, coming to the NHS from Flybe, the Exeter-based airline, where she was Director of People. Prior to her Flybe role, Hannah also held top strategic posts for the Church of England and global educational provider Pearson, helping both organisations develop key culture and organisational growth programmes. As well as strategic and business acumen, Hannah brings a strong voluntary and charitable ethos to both the RD&E and NDHT.

Hannah actively supports a number of charities, including being a Trustee of Exeter homeless support charity St Petrock's, and she is a member of the Greater Exeter Skills Board.

Carolyn Mills, Chief Nursing Officer

Carolyn joined the RD&E and NDHT as joint Chief Nursing Officer in January 2021. Carolyn is an experienced nurse whose career in the NHS spans over 30 years, including working in the acute, community and academic sectors. Previous to joining the RD&E and NDHT, Carolyn worked for Hillingdon Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust in Assistant Chief Nurse positions and was Director of Nursing at NDHT between 2005-2014.

From 2014 to 2021, Carolyn was Chief Nurse at University Hospitals Bristol & Weston NHS Foundation Trust, where she had experience of merging together University Hospitals Bristol NHS Foundation Trust and Weston Area HealthTrust.

Angela Hibbard, Chief Finance Officer

Angela joined the NHS in 2003 as a management accountant in South Devon and Torbay NHS Trust. She joined Royal Cornwall NHS Trust in 2008 to lead their medium term financial and cost improvement planning, before moving to the South West Specialised Commissioning Team. During the transition into the new commissioning structures in 2012, Angela took on the role of Head of Finance for NHS England leading on the finance function for commissioning of primary care. She joined the Northern, Eastern and Western Devon Clinical

commissioning Group as Deputy Chief Finance Officer in 2014, before moving to NDHT as Director of Finance in 2018.

Angela was appointed as Chief Finance Officer for the RD&E and NDHT in January 2021.

John Palmer, Chief Operating Officer (interim from April 2021, substantive from August 2021)

John's extensive public sector career spans nearly 25 years and includes executive roles in healthcare, local government, the senior civil service and management consultancy. Before being appointed Deputy Group Chief Executive and Site Chief Executive (Denmark Hill) at King's College Hospital NHS Foundation Trust, John was the Chief Operating Officer of Cwm Taf Morgannwg University Health Board, overseeing the delivery of primary, community, hospital and mental health services to 450,000 people across the South Wales Valleys. Prior to this, John worked in a series of national roles in the Cabinet Office, Welsh Government and NHS Wales, having started his career in the Royal Brompton Hospital and then local government in Hertfordshire and Monmouthshire. Most recently, John has been the Silver Commander for North West Anglia Foundation Trust through the COVID-19 second wave.

John joined the RD&E and NDHT as Interim Chief Operating Officer on 12 April 2021, before being appointed as Chief Operating Officer on 16 August 2021.

Chair and Non-Executive Director appointments

The Chair and NEDs are appointed by the CoG acting on the recommendation of the Nominations Committee, which is a committee of the CoG.

The Chair chairs the Committee when appointing NEDs, with the Committee chaired by the Lead Governor when dealing with matters related to the Chair.

During 2021/22 the Nominations Committee completed the following appointments (see the section The Governors' Year below for more detail:

- Two new NEDs – Carole Burgoyne and Bridie Kent – were appointed for terms of three years from 28 June 2021 to 27 June 2024
- Alastair Matthews was re-appointed for a further three years from 1 October 2021 to 30 September 2024
- A new Chair-Dame Shan Morgan – was appointed during the Autumn of 2021. Dame Shan takes up her post from 1 April 2022.

Membership of Nominations Committee
(as at 31 March 2022)

- Chairman of the Trust – James Brent (Chair)
- Lead Governor-Peta Foxall
- Deputy Lead Governor-vacant
- Hugh Wilkins (Exeter & South Devon)
- Faye Doris (Exeter & South Devon)
- Barbara Sweeney (East Devon, Dorset & Somerset & Rest of England)
- Rachel Noar (East Devon, Dorset & Somerset & Rest of England)
- Peter Flatters (Mid, North, West Devon & Cornwall)
- Annie Adcock (Mid, North, West Devon & Cornwall)
- Hazel Hedicker (Staff)
- Angela Shore (Appointed)

The Committee is also supported by the Senior Independent Director when dealing with matters related to the Chairman's appraisal and in relation to the recruitment of a new Chair.

Non-Executive Director Remuneration Committee

The Non-Executive Director Remuneration Committee (NEDRC) is made up of Governors and is chaired by the Lead Governor. The Committee is supported by the Chief People Officer.

Recommendations for any changes to remuneration for the Chair and other NEDs are made by the NEDRC for consideration by the CoG at a general meeting. The Committee did not meet during 2021/22, having met in February 2021 in order to consider the levels of remuneration for the NEDs and for the recruitment of a new Chair during 2021. It will meet early in 2022/23 to consider NED remuneration following the merger between the RD&E and NDHT and ahead of NED recruitment campaigns during the year.

Membership of NEDRC (as at 31 March 2022)

- Peta Foxall (Lead Governor and Chair of the NEDRC)
- Vacancy (Deputy Lead Governor)
- Hazel Hedicker (Staff Governor)
- Barbara Sweeney (East Devon, Dorset, Somerset and the Rest of England)
- Vacancy (Exeter and South Devon)
- Vacancy (Mid, North, West Devon and Cornwall)
- Vacancy (Appointed Governor)

Our Governors and members

Council of Governors (CoG)

The Trust's CoG is an integral part of the RD&E's governance structure, providing a vital connection between the Trust, its members and the public. During the year, the CoG has ensured that it has carried out, as effectively as possible, its joint roles of:

- holding the Board of Directors accountable and;
- representing the views of members and the wider public to the Trust

In carrying out these duties, the Trust seeks to support the CoG and individual Governors to ensure that there is both the means and capacity to undertake its responsibilities effectively. At the same time, the Trust is mindful that the CoG is an elected representative voluntary body that has a distinct role separate to that of the Board of Directors.

The global pandemic had a significant impact on the work of the CoG but, as in other parts of the Trust, the CoG rapidly adopted new ways of working, primarily through the use of video technology which enabled the CoG to carry out its core duties. Throughout the last year, Governors continued to do their best at ensuring the public voice was present in key discussions but many Governors experienced some issues in ensuring that they stayed in touch with constituents during lockdowns.

It is also clear that the pandemic has impacted on the quality of interaction between Governors and NEDs. The relationship is one in which both the Board and CoG share the same broad objectives of acting in the interests of the organisation and patient care whilst retaining sufficient distance to enable the CoG to act as a critical friend, whilst ensuring that the Board is acting in the best interests of members and the public, and has the right mix of experience and skills within the NEDs to manage the key challenges facing the Trust. The NEDs regularly attend CoG meetings for informal face-to- face meetings as well as more formally representing some of the work they are responsible for at CoG meetings. Regular attendance by Governors at the public Board meetings has also helped to enable the Governors to see the Board 'in practice' as well as help provide intelligence that individual Governors have used in contributing to the performance assessment of individual NEDs. Governors have been able to use video technology to have access to the public part of the Board meeting and raise questions as appropriate.

The Trust has an "Engagement Policy", agreed between the CoG and the Board of Directors, to help manage situations in which the CoG's concerns about the performance of the Board of Directors or the welfare of the Trust have not been resolved through the normal channels. This policy was not required at any time during the year. In addition, the Senior Independent Director acts as an independent facilitator through which concerns about the Board or the Chairman can be managed if appropriate. This policy was not needed during the year.

The CoG met four times during the year to conduct its core business. During these meetings, the CoG collectively considers the performance of the Trust over a quarter, highlighting any issues or concerns it may have in relation to the way in which the Board of Directors is managing performance. The performance report, which essentially summarises the performance information that goes to the Board, contains information about the Trust's operational performance and its adherence to various national targets, its financial performance and quality.

The Governors met an additional four times to consider work related to NED and Chair appointments and for consideration regarding the proposed integration with NDHT.

Key highlights for Governors year 2021/22

Appointments to the Board of Directors

The Nominations Committee had a busy year in 2021, playing a vital role as the RD&E worked towards the integration with NDHT. The purpose of the Committee is to select candidates to be Chair and Non-Executive Directors of the Trust, for subsequent recommendation to, and appointment by, the Council of Governors. This work considers the policy for the composition of the Non-Executive Directors, and the skills and experience required on the Board.

Throughout its work, the Committee was consulted on and took account of plans for the RD&E Board up to the proposed merger date and then on the structure and composition of the Board from April 2022, after the merger based on assumption that it would proceed as planned. With the post-merger structure agreed, the following appointments were made.

Appointment of a new Chair

The Trust appointed a new Chair in September 2021. Dame Shan Morgan's appointment as Chair from 1 April 2022 was approved by the Council of Governors at a meeting on 11 September 2021 on the recommendation of the Nominations Committee. Dame Shan will take on the role for an initial term of office of three years and succeeds current Chairman James Brent, who came to the end of his term of office on 31 March 2022. Dame Shan was appointed following a robust recruitment process, with an appointment panel made up of stakeholders representing both organisations.

Appointment of two Non-Executive Directors

The Trust recruited two new Non-Executive Directors in 2021, one with social care and local government experience (to replace Jane Ashman who left the Board in September 2020) and one with clinical skills and experience (to replace Hisham Khalil, who left the Board in June 2021). The Nominations Committee long-listed and then short-listed candidates with interviews taking place in May 2021. The appointments of Mrs Carole Burgoyne (social care and local government) and Professor Bridie Kent (clinical) were approved by the Council of Governors on 11 May 2021. Both Carole and Bridie took up their posts, which are for terms of three years, on the Board on 28 June 2021.

Re-appointment of a Non-Executive Director

The Nominations Committee made a recommendation to the Council of Governors at its meeting on 20 August 2021 to re-appointment Mr Alastair Matthews as a NED for a further three-year term from 1 October 2021. Noting Mr Matthews' strong performance as NED, including his highly effective chairing of the Audit Committee and Integration Programme Board, the CoG unanimously agreed that Mr Matthews be reappointed.

Appointment of NDHT NEDs to the post-merger Board of Directors

As part of the work on the composition of the Board after the merger, the Nominations Committee made a recommendation to the COG that two NEDs from NDHT, Mr Kevin Orford and Mr Tony Neal, be appointed to the Board. This brings both Mr Orford's and Mr Neal's experience and knowledge of NDHT to the new Board, alongside Mr Kirby and Professor Kent who also joined the NDHT Board as NEDs during 2021/22.

The Committee also undertook a routine review of its Terms of Reference to ensure these remained fit for purpose. The Terms of Reference were approved by the CoG at its November 2021 meeting.

Chairman/NED Appraisals

The CoG provided feedback that was used as part of the appraisals of the NEDs. The Senior Independent Director conducted the annual appraisal of the Chairman which included feedback from the Council as part of the process. All appraisals were satisfactory.

Integration with NDHT

The CoG played a key role in the proposed integration with NDHT in line with their statutory duties. The Governors had a role in approving the RD&E's application to acquire NDHT and for the RD&E to enter into a Significant Transaction. To fully undertake this role, the Governors had to decide whether the Board of Directors had been thorough and comprehensive in reaching its decision to integrate and that it had also obtained and considered the interests of Foundation Trust members and the public as part of the decision-making process. It was important therefore that the Board helped Governors with their decision by providing appropriate information and ensuring they were equipped with the skills and knowledge they needed to fulfil their role. To this end the Governors received updates at all the formal CoG meetings and at the development days throughout the year (see below for more details). Alongside work undertaken by the Nominations Committee in terms of NED appointments, Chair recruitment and looking ahead to the composition of the post-integration Board of Directors, there was also a review of the recently revised RD&E Constitution to ensure it met the requirements of the transaction guidance issued by NHSE/I and to also ensure that it would reflect the enlarged Foundation Trust in terms of the composition of the CoG. Working groups were established with membership from across both the RD&E and NDHT. This included Governors and patient / public representatives and staff from NDHT.

Council of Governor meetings

In addition to the standard agenda items: performance report, working group updates, election updates, operational and strategic updates from Chairman and CEO, there were regular progress reports on the proposed integration with NDHT along with the following issues discussed at the formal routine meetings and the additional CoG meetings:

May 2021

- An extraordinary confidential meeting was called to consider recommendations from the Nominations Committee in relation to the appointment of two Non-Executive Directors (Carole Burgoyne and Bridie Kent).

June 2021

- There was an update on the routine review of the RD&E's Constitution
- The CoG approved the Governors' Code of Conduct and Standard Operating Procedure for the Alleged Breach of the Governors' Code of Conduct following detailed review, led by a working group of Governors.
- The CoG received updates on the work of the NED Remuneration Committee and Nominations Committee in relation to the recruitment of a new Trust Chair.

August 2021

- The CoG received, for completeness, a copy of the revised Constitution following its approval during July 2021.
- The CoG approved the agenda for the Annual Members Meeting due to take place in September 2021.
- An update on progress with the recruitment of the new Trust Chair was provided and the CoG also approved a recommendation from the Nominations Committee that Alastair Matthews' be re-appointed as a NED from October 2021.

September 2021

- An extraordinary confidential meeting was held for the CoG to receive and approve the recommendation for appointment of the new Trust Chair.

October 2021

- An extraordinary confidential meeting was held for the CoG to receive and note the satisfactory annual appraisals of the Chairman and Non-Executive Directors. The CoG also received and considered the Report on the Performance of the External Auditors.
- The CoG also received an update on progress with the integration with NDHT and approved the revised Constitution for the Trust, should the integration go ahead.

November 2021

- The CoG reviewed its Register of Interests, following the recent intake of new Governors in September 2021.
- It approved the Terms of Reference for the Nominations Committee and NED Remuneration Committee following their routine reviews.
- The Report on the Performance of the External Auditors was received in the public meeting to ensure this was recorded in the public minutes.
- The Council reviewed the success of the Annual Members meeting and also received its annual membership update.
- The CoG was kept updated on the progress with the appointment of the Chair.

February 2022

- The CoG had an update from Carolyn Mills, Chief Nursing Officer on Patient Experience and the Trust's strategy.
- The CoG reviewed and approved its schedule of reports for 2022/23.
- The CoG reviewed and updated its Committee and Working Group membership report.
- There was a discussion with Carole Burgoyne, NED, on her time as a NED since her appointment in June 2021 and her portfolio and priorities.
- In its confidential meeting, the CoG approved the appointments of Mr Orford and Mr Neal as NEDs to the post-transaction Board of Directors should the proposed merger be approved.

March 2022

- The CoG met and approved the RD&E entering into a Significant Transaction and for it to submit a joint application to NHSE/I to acquire NDHT.

CoG Development Days

Building on the training and development undertaken in the early part of 2021, the key focus for the Development Days during 2021/22 was the CoG's vital role in the proposed transaction with NDHT and ensuring the Governors were equipped with the skills and knowledge they needed to fulfil their role. Other issues were also discussed throughout the year.

May 2021

- The focus was on informing the CoG on the transaction Due Diligence process – what the purpose of the process was, the approach that was being taken, the timetable and when the outcomes could be expected. The CoG discussed how this Due Diligence would provide assurance and identify risks.
- The Governors were also updated on the approach to developing a name for the enlarged Foundation Trust and on the plans for engaging the public, Trust Members and stakeholders throughout the integration process.

July 2021

- This was a Joint CoG and Board Development Day (both RD&E and NDHT Board) focussed on the CoG and Boards working together on the Trust's purpose, values and culture. This was part of the work to develop a vision and values and behaviours as part of the proposed integrated Trust's corporate strategy. Governors and Board members worked together in small groups to start to describe a draft vision statement and a draft set of values and behaviours.
- The CoG separately also received an update on the Chair recruitment process.

November 2021

- This was a Joint CoG and Board Development Day (both RD&E and NDHT Board) and involved a detailed discussion on providing information and assurance in relation to the integration Full Business Case.
- The CoG also met separately to look ahead to the November 2021 CoG meeting, which would be the first such meeting for those Governors who joined the CoG in September 2021. There were small discussion groups to set out the format for the day, how CoG meetings are structured and to allow for the newly elected Governors to ask questions and to get know their Governor colleagues.

January 2022

- The CoG received an update on progress with the integration, including on the Full Business Case process. There was a communications and engagement update and a discussion on the CoG meetings in February and March 2022 to ensure the Governors had the information they needed ahead of a formal vote at the end of March 2022.
- The CoG also receive a strategic update on local, regional and national healthcare issues and discussed the feedback Governors were hearing in their local communities.
- There was a discussion on the Governor working groups and how these may be organised and managed going forward.

March 2022

- The CoG agreed that this development day be entirely focussed on the integration and be given as an opportunity for Governors to raise any significant questions or concerns ahead of its formal vote to approve the integration. Supported by the Chairman and Non-Executive Directors, Governors were able to ask questions and seek assurance on any issues they may have.

The work of the CoG

The CoG continued to organise itself through three key working groups:

- CoG Effectiveness
- Public and Member Engagement
- Patient Safety and Quality

CoG Effectiveness Working Group

The Group met four times during 2021/22. A number of its members also participated in the Constitution Reviews. It also led on a number of document reviews, such as the CoG Rules of Procedure and the Working Group Terms of Reference which were subsequently presented to the CoG for approval. Early in 2022 it agreed the template for the annual CoG Effectiveness Review to consider what had gone well over the previous year and to identify areas for improvement. It considered the report at its March 2022 meeting and is working to develop an action plan. With a significant number of document reviews undertaken in 2021, the Group is keen to shift its focus back to working to ensure the CoG is as effective as it can be in undertaking its role. There were changes to the Group's membership throughout the year, including to its Chair and Vice Chair, ending the year without a permanent Chair or Vice Chair in place.

Public and Member Engagement Working Group

The purpose of the working group is to ensure that the Council of Governors is meeting its duty to represent the interests of members of the Trust and

the interests of the public and contribute a Governor perspective to the development of the Trust's engagement work. The group met on four occasions.

The key emphasis of meetings throughout the year was on:

- the proposed 'Integration Programme' and 'Member Recruitment' planning. This included ensuring that members were informed alongside the public. Discussion also focused on ways of recruiting new public members, focussing on Northern Devon and how to make such a campaign effective.
- ensuring that the message on planned elections reached the public
- supporting and improving Governor induction
- being informed on the emerging Patient Experience Strategy

Patient Safety and Quality Working Group

The Group met twice during the year, with two planned meetings in May and September 2021 stood down. It met in December 2021 and February 2022 and considered how it wished to manage the Governors' Quality Priorities for 2021/22 and 2020/21 as updates to the CoG had been impacted by the pandemic. It discussed the Trust's work to revise its patient experience strategy and an update on this was provided to the CoG at its February 2022 meeting. There were changes to the Group's membership throughout the year, including to its Chair and Vice Chair, ending the year without a permanent Chair or Vice Chair in place.

Governor expenses

The aggregate claims for expenses from Governors during the year 2021/22 was £60. In 2020/21 the figure was £91.05.

The CoG agreed to a new policy of reimbursing Governors to a maximum of £30 a year for miscellaneous expenditures connected to their work as a Governor such as printing, consumables etc.

Our Members

The Trust is a public benefit corporation and Foundation Trust that exists for the purpose of providing healthcare services to the population it serves. Membership is a distinguishing feature of FTs which brings with it substantial benefits and all FTs are obliged, through legislation, to have members. As a membership organisation, the RD&E endeavours to reach out to inform members about what is happening at the Trust as well as listening to their concerns and opinions on service delivery, on how to improve patient experience and on influencing its longer-term strategy.

- Members were given regular updates on the Trust's latest developments and invited to take an active role in the Trust's plans for the future through participating in online events and surveys, attending our AMM and playing a key role in voting for Council of Governor members. Throughout the year Members were kept informed of our plans for integration including being involved in the development of our new name.
- Other opportunities for members to share their views included participation in our Patient Experience Survey aimed to gather initial thoughts on our new patient experience principles, and Patient Experience Strategy 2022-25 Survey. Our members feedback from both these surveys will be invaluable in helping to shape how we continually improve the experience of our patients at NDHT and RD&E over the next three years.
- During the year our plans for in-person member engagement events were given full consideration. On reviewing the local COVID-19 position and having gathered feedback from our members via on online survey the decision was made to host both our Medicine for Members Seminar, featuring Dr David Strain the RD&E's Clinical Lead on COVID-19 and our Annual Members Meeting virtually using MS Teams.

About our members

Having a membership base allows a meaningful relationship to be developed between members and the Trust. Developing this engagement helps us to deepen our understanding of their views and opinions which we can correlate to the views of the wider community. Developing an on-going dialogue with members provides an opportunity for the Trust to develop its thinking, test ideas, and give members an overview of potential future strategic options which it can then engage with members on in a way that genuinely allows for influence and boundary setting (i.e. options which members would find unpalatable for example).

The ongoing conversation with our members – expressed primarily through our Members' Say/Day events, through surveys of members and in the feedback from Governors – is a very important aspect of the Trust's work that provides genuine added value in informing its work, whether that is in a relatively minor operational detail, potential service change, ways to improve services in the best interests of patients/public or on bigger and more strategic issues. During the year the Trust continued to provide regular updates to members during the pandemic but other than the online engagement exercise with members at the Annual Members meeting – see below.

Annual Members Meeting (AMM) 2021

All Trust Members (public and staff), Governors and other stakeholders were invited to join our virtual AMM and preceding engagement event on 29 September 2021. The decision to run the event virtually was based on the need for social distancing due to the COVID-19 pandemic.

The Annual Members' Meeting provided an overview of the previous financial year, the accounts and plans for future by the RD&E's Chief Executive Suzanne Tracey and Chair, James Brent. This was followed by an assurance report from our external auditors and a roundup of the Governors' year by Lead Governor Peta Foxall.

Members of the RD&E submitted a motion at the Annual Members Meeting to thank staff and volunteers at the RD&E for their hard work throughout the COVID-19 pandemic.

The Motion, signed by five Trust members: Michael Golby, Gerry Hinton, Stephen Hudson, John Phillips and Simon Timms, said: "The whole nation owes a deep debt of gratitude to the NHS for its magnificent response to the COVID pandemic.

"Members of the RD&E NHS Foundation Trust have seen first-hand the heroic way in which the Trust's staff and volunteers have risen to meet the unprecedented challenges that they have been faced with over the past 18 months. Their personal commitment, professional skills and sheer hard work have helped so many patients and their families through these difficult times.

"Trust Members attending this Annual Meeting therefore wish to place on record their sincere thanks to everyone at the RD&E Trust, across all its teams and locations, for their outstanding performance. We ask our Trust's Chair to let them know how very much Members appreciate all that they have done-and continue to do-in such challenging circumstances."

James Brent, Chairman at the RD&E and NDHT, said: "I'd like to express my thanks to our members for this formal vote of thanks. Their support to our staff and volunteers throughout the pandemic is really appreciated and I shall be delighted to pass on our Members' thanks in accordance with the motion."

Simon Timms, RD&E member, said: "The Annual Meeting gives us, as Trust members, the opportunity to express our formal thanks to everyone at the RD&E. I am delighted to propose this motion which recognises their outstanding work in such challenging times."

GOVERNOR PROFILES

(Updated October 2021)

Governors in post Governors in post as at 31 March 2022'

East Devon, Dorset, Somerset and the rest of England	
Peta Foxall - Lead Governor	Having initially joined the CoG as an Appointed Governor in 2013, Peta was elected as a Public Governor in 2016 and re-elected in September 2019 for a further term of three years. Peta is Lead Governor and was elected to that role by her peers in 2017 and re-elected at the end of 2020. Peta has extensive experience of leading and working in multi-professional teams, primarily within the NHS, higher education and charity sector. She contributes the voice of patients to the work of governors, based on her experiences and those of fellow patients. Peta is a committed advocate for social action that is inclusive and shows that by volunteering in local communities and at a national level as chair of The Wildlife Trusts and it's Our Bright Future steering group and as a member of the #iwill Partnership, supporting young people to lead on the key issues that connect health and care, wellbeing, education and the environment.
Barbara Sweeney	Barbara was elected as a public governor in September 2017 and re-elected in 2021 for a term of two years. She has lived in East Devon for over 40 years and has recently retired from further education where she worked in governance. During her working career she has also held senior positions in management in healthcare and in higher education. Three of her four children work in the NHS and her late husband was a Professor of General Practice in Exeter. Her particular interest is in the quality of patient experience. She is a strong advocate of remembering the person within the patient, so that they are viewed as an expert and collaborator, rather than recipient, by their healthcare teams. Barbara is a Trustee at Hospiscare. Other voluntary roles are as a lay member of the Patient and Public Involvement Group at the University of Exeter's Academy of Nursing and as a Governor on the Local Governing Body of West Exe School, part of the Ted Wragg Multi Academy Trust. Previous Board experience includes eight years as a Governor of Exeter College.
Kay Foster	Kay Foster has been a Governor since 2014, and was most recently re-elected in 2021 for a term of two years. Kay is a retired State Register Nurse/Midwife with thirty years of nursing experiences. Eighteen years serving as a Nursing Officer with the Queen Alexandra Royal Army Nursing Corps, retiring as a Major. She gained a wide variety of experiences with international postings, including Saudi Arabia during the First Gulf War. She has a BSc (Hons) in Health Services Management. During her time as a Governor, Kay has been a member of several subcommittees and working groups. During the COVID-19 Pandemic 2020-21 first lockdown, Kay worked closely with the Budleigh Hub, supporting GPs with referrals for volunteers to help with shopping, prescriptions and phone buddies for the Exmouth Community. In August 2020, she became a volunteer at the Nightingale Hospital and developed the role of volunteers' coordinator working on the wards caring for COVID-19 patients. Kay is very proud to be a Governor at the RD&E Foundation Trust. Governors attends high-level meetings and read many documents monitoring performance of the Foundation Trust. Observing that the NED's challenge the Board by understanding areas where performance indicators are adequate/inadequate. Also as a Governor she is an ambassador for the Trust and an advocate for the community

Rachel Noar	Rachel was elected in September 2019 for a term of 3 years. Rachel is Deaf and lives in Ottery St Mary. Her family's first language is British Sign Language (BSL). Rachel worked with young Deaf people at Derby College, as an Independent Support Worker, encouraging them to develop independent living skills. She went on to study Contemporary Arts/ Computer Animation, gaining an MA. She became a consultant for a disability board for East Midlands Art Council and was a member of the board of EQUATA, an arts agency for Deaf/disabled. She worked as an Advisory Deaf Inclusion worker for DCC. Rachel supported hearing families with deaf babies/toddlers. This job centred on giving parents confidence to develop their children's language skills. She also worked with nurseries and schools to develop the inclusion of Deaf children in mainstream situations. Since developing MS, she has become the full-time mother of two boys.
Heather Penwarden	Heather was elected as Governor in September 2021 for a term of two years. Heather is a retired Mental Health Nurse, Cognitive Behaviour Therapist and Clinical Supervisor. She enjoyed every minute of her long career working within the NHS in Devon gaining valuable experience on busy wards, in community settings, GP practices, and as a tutor at Exeter University. She has lived experience of being a long-term carer and is passionate about communities working together and in partnership with the statutory care agencies. In her local community of Honiton, Heather has served as Chairman of Governors of Mill Water Special School, Chair of Honiton Arts Society and in retirement she is founding Chair of Dementia Friendly Honiton and is currently Chair of the Honiton Hospital and Community League of Friends. Heather is a strong believer in our NHS being accessible and inclusive for those who need it, she is an active member of any committee she sits on and approaches everything with an open and curious mind.

Exeter and South Devon

Faye Doris	Faye was elected in September 2016 for a term of three years and was re-elected in September 2019 for a further three years. She lives in Exeter and is a retired nurse, midwife, and Associate Professor of Midwifery for the University of Plymouth. She has been an active member of the Council of Governors at RD&E NHSFT and was elected Deputy Lead Governor in 2018. Faye is a member of the RD&E NHSFT Patience Experience Committee, the Equality, Diversity and Inclusion Steering Group and the Nominations Committee. She brings to the Council, experience of leadership and management, listening and responding to stakeholders, student, staff, and patient feedback. As a Governor, she has seen the care, safety and wellbeing of patients and staff, crucial during the COVID-19 pandemic. She supports all aspects of inclusivity and is a member of the Deaf and Hard of Hearing Working Group at RD&E NHSFT. She believes in the NHS providing safe and effective care that is kind, compassionate and fair to all.
Janet Bush	Janet was elected as a Governor in 2021 for a two-year term. She is a writer and editor specialising in economics. She has worked for management consultants McKinsey & Company for the past 15 years, working on major reports on global trends. Before that, she was a national newspaper and broadcast journalist working for Reuters, The Financial Times, the BBC, and finally The Times where she was Economics Editor. She moved to Devon 20 years ago and has lived in Exeter for the past five years. She was treated at the Royal Devon & Exeter six years ago for a serious condition, and now is keen to serve the hospital in any way she can.

Hugh Wilkins	Hugh was elected as a Governor in September 2021 for a term of two years. Hugh is a clinical scientist with 40 years' experience in service delivery, education and research in hospitals and universities in the UK, Africa and Asia. Much of this work has involved support for the safe and effective use of radiation in diagnosis, treatment and research. He has worked in the public, private and charity sectors. He has been elected to fellowships of five institutions including the Higher Education Academy and the Chartered Management Institute and is a Senior Associate of the Royal Society of Medicine. He took particular satisfaction from a Cabinet Office CharterMark award for public service excellence to an NHS team which he led. His current portfolio combines voluntary, consultancy, advisory, qualified expert, educational and leadership roles. This includes review of clinical trial proposals for the Health Research Authority, curriculum design and development for the Patient Safety Movement Foundation, and topic leadership for the charity Patient Safety Learning.
Elizabeth Witt	Elizabeth was elected as a Governor in September 2021 for a term of three years. Elizabeth is a retired registered Nurse, with a background in both NHS clinical and occupational health and safety. Elizabeth is a member of the Southwest Ambulance research Group and a national health and safety environmental auditor for St John Ambulance, liaising with the Care Quality Commission. Elizabeth has held previous roles as director of the former Hospital Savings Association, was a former Director of Devon Healthwatch and was a Public Governor of the Norfolk and Suffolk Mental Health Trust Foundation. Elizabeth has a strong interest in the quality of life and services available to people living in our communities and is keen to see service users placed at the heart of everything the local health and social care services may offer.
Olwen Goodall	Olwen was elected as Governor in September 2019 for a term of three years. Now retired from lecturing at Exeter University, her work has been in education and psychology. As a teacher, psychologist and lecturer for over 40 years, she has worked with all ages in a wide variety of contexts. She has been a school governor for 17 years. Olwen has volunteered regularly-helping to set up & work with the Exeter Rape Crisis Line and now at the Foodbank. In her role as RD&E Governor, she hopes to represent and advocate for service users and their families. She has recent experience of providing an outsider's perspective, both teaching at the medical school and also public involvement in medical research. Olwen looks forward to supporting the work of a hospital she greatly respects.
Desmond Kumar	Desmond was elected in 2019 for a three-year term. Born in Guyana on a sugar plantation next to the Demerera river, his family arrived in London in 1962, where he went to school and then moved to Exeter to study Mathematics and Economics at the University. After qualification, he joined the Devon & Cornwall Police force and was posted all around Devon. After running his own business, he taught at Blundell's School, later moving to schools in Ottery and Honiton. During this time he coached hundreds of young people basketball, many who have gone on to represent their country and played in Europe and the USA. He is passionate about supporting our young people and believes that we all need to do our bit to help our community.

Mid, North, West Devon and Cornwall	
James Bradley	James was first elected in 2014 and was more recently re-elected in September 2021. James was a Chartered Environmental Health Officer and Chartered Safety and Health Practitioner who having completed a military career had worked in Local Government, the National Health Service and finally as an international consultant. He is a Member of Devon County Council's Commissioning Involvement Group; participates on the South West Academic Health Science Network Quality Improvement Partner Panel; is a Patient and Public Voice Expert Advisor, University of Surrey's Therapeutic Radiographer and Dietitian Prescribing Study; a Trustee of West Devon Community and Voluntary Services; a Treasurer, Devon Health and Social Care Forum and a Member of the Patient Participation Panel at South Western Ambulance Service NHS Foundation Trust. James is a passionate and committed individual in regard to ensuring that the public voice and perspective is always articulated and the patient perspective is heard whenever and wherever the need arises. His hobbies include gardening, stamp collecting and helping others, especially his wife. James lives with his wife and cat near Okehampton.
Peter Flatters	Peter was elected Governor in September 2019 for a three-year term. His previous career concerned the collection, interpretation and presentation of scientific data. After University he worked for ICI as a Field Team Leader, conducting Agrochemical Trials on farms across Southern England. Later, he moved into R&D Planning with ICI before transferring to the University of Bristol's Long Ashton Research Station. When the Research Station closed, he became a Sub-Postmaster in a Devon village. He ran the PO for eight years, steering people through varied business, from Fishing Licences to Banking and guiding pensioners through the transition to chip and PIN cards. His background in science, regulation and customer service provides a sound preparation for Hospital Governance.
Monika Herpoldt-Bright	Monika was elected for a three-year term in September 2019. She is a retired Cabin Service Director with a degree in education who lives just outside Crediton. Having been raised and educated in Exeter she is very aware of the needs of the community. She has volunteered for the past 16 years as a Samaritan and was privileged to be their Director. She now has a national role as a Quality Mentor. Having been a cancer patient and more recently having had one of her sisters undergoing major surgery she is very aware not only of the negative aspects of the hospital, but more especially what an amazing asset to the community the RD&E is.
Annie Adcock	Annie was elected for a two-year term in September 2021. Annie moved to Devon in 2017 from Somerset where she served as a Public Governor in the NHS Foundation Trust for 5 years. She was blessed in 2018 with a knee replacement at RDE and is currently a patient within the Trust. Thus she brings both personal and professional experience to this varied role of Public Governor. Her working life involved teaching within Special Educational Needs and a management role within a charity establishing Communities for People with Learning Disabilities. I am passionate about listening to the individual and encouraging 'empowerment' to bring about transformation in community life. The Members and patient's NHS experiences should inform future planning within the local area where their physical, mental and social care needs are met. She hopes to find creative ways to engage with the constituency and the Trust.

Staff	
Hazel Hedicker	Hazel was first elected in 2013 and was more recently re-elected in September 2021. Following a career in the hospitality industry, Hazel commenced employment with the NHS in 1994 and joined the RD&E in March 2000 having previously worked for another large acute Trust in the South West. Having spent 16 years as a senior operational manager within two Facilities divisions, her career changed direction and she joined the Transformation Programme Team in May 2012. Hazel has since project managed numerous trust-wide transformation projects supporting colleagues with both clinical and non-clinical redesign and change. From October 2018-February 2021 she project managed the Clinical Pathway Improvement workstream within the MY CARE programme. She has recently joined the NDHT and RD&E Integration Programme team as Clinical Strategy Project Manager. Hazel holds a Master's degree in Business Administration and is a fully qualified Prince 2 Practitioner. She has a keen interest in Communications & Engagement, in particular the engagement of patients, carers and staff with service redesign and change.
Rob Biggar	Rob was elected as a Staff Governor in September 2019 for a three-year term. He is the lead physicist in radiotherapy treatment planning, with a background of 10 years providing service development and direct patient care, within oncology. Rob has experience at different NHS trusts across Merseyside and Wirral before moving to the RD&E. Rob's role requires solving complex clinical, scientific and technical problems relating to bespoke radiotherapy treatments, improving patient safety and cancer outcomes. He is a member of the Institute of Physics and a chartered scientist.
Anum Shuja	Anum was first elected in September 2019, and was re-elected for an additional three years in September 2021. Anum has over a decade of experience in client services and relationship management. She has worked for both, the private and not for profit sector including Canada's Revenue Agency, post-immigration support agency, a leading commercial bank and now the NHS. Anum joined the RD&E in 2018, as a Patient Experience Lead for the Community Services Division. This allowed her to continue her ambition of working in the service industry in a role that focused on care for others. Anum is passionate about the NHS as a service user and an employee. She believes that the organization should continue to strive for the highest level of care, by ensuring the staff, patients and carers are at the centre of every decision made. Anum is a vocal and valuable member of the Council of Governors. She is particularly interested in improving communications between the Trust and its stakeholders, and as the Chair of the 'Public and Members Engagement Group'; she wants to support the Trust in achieving this. In her spare time, Anum enjoys spending time with her family and volunteers at her local school.
Simon Leepile	Simon Leepile was elected as Staff Governor in September 2021 for a two-year term. Simon was a farmer in South Africa and worked in a building society before moving to the UK where he joined RD&E in 2008 working in Domestic services. In 2015 he was Elected as Unison Representative for RD&E and later joined Staffside, as a rep for RD&E and NDHT. He passionately believes good standards of cleanliness in our Hospital and community sites reduces infections and promotes a good quality of life. He also supports the NHS training existing unskilled employees to help tackle the staffing shortages. Simon has used his Staffside time to train colleagues in basic use of computers, to enable them to access information and complete training. He is also passionate about improving communication between management, staff and patients to improve service delivery. He believes in charitable work and helping those in need. Simon spends his spare time with his family and enjoys watching the Springboks play rugby. He is a member of The Mint Methodist church in Exeter and registered with Exeter City Council as a Taxi driver.

Appointed	
Cllr Ian Hall	Councillor Ian Hall is one of two appointed Governors and represents Devon County Council starting his term of office in June 2021, running until May 2024. As a District and County Councillor for his hometown of Axminster and its surrounding parishes, Ian has a deep passion for improving public services in both the local community and Devon as a whole. Ian believes that if we put the physical and mental health of individuals at the heart of public services then we will provide more resilient and prosperous communities. During his time as an elected member, he has been designated as a Mental Health Champion for DCC and pushed hard for protections against the most vulnerable in society. This passion permeates outside of his political work in his roles as chairman of Cloakham Lawns (a sports charity which promotes 'education through sport' for all ages) and vice-chair of ARC (a unique mental health charity which provides rapid support for the community whilst taking pressure of public services). Ian looks forward to supporting the work of a hospital that has so kindly helped personal relations in the past.
Professor Angela Shore	Angela was appointed on behalf of the University of Exeter in October 2016 and was re-appointed in October 2019 for a further three years. She is Professor of Cardiovascular Sciences and was Vice Dean Research at the University of Exeter Medical School until 2019. Angela is principal investigator of a large team of scientists and clinicians in vascular medicine based at the hospital. She co-leads the Exeter Centre for Excellence in Diabetes Research with Andrew Hattersley. As Scientific Director of the Exeter NIHR Clinical Research Facility she facilitates Experimental Medicine Research for the RD&E/ Medical School collaboration. Angela is currently Chair of the Diabetes and Wellness Foundation project and fellowship committees and a member of the Diabetes Research Steering Group 6 (complications) led by Diabetes UK. Angela was President of the British Microcirculation Society 2017-2020 and Treasurer for the European Society for microcirculation for over 10 years. She is a member of the International Liaison Committee for World Microcirculation Research.

Professor Angela Shore

Other Governors in post during the year

- Bob Maskell (East, Devon, Dorset, Somerset and Rest of England) until September 2021
- Tony Wilkinson (East, Devon, Dorset, Somerset and Rest of England) until December 2021
- Tony Ducker (Exeter and South Devon) until September 2021
- Michael James (Mid, North, West Devon and Cornwall) until May 2021
- Marcus Pipe (Mid, North, West Devon and Cornwall) until September 2021
- Catherine Geddes (Staff) until September 2021
- Dominic Hazell (Staff) until September 2021
- Mascia Checoni (Staff) September to November 2021
- Phil Twiss (Devon County Council Appointed Governor) until June 2021

Governors can be contacted via email at: royaldevonmembers@nhs.net

The Governor's Register of Interests is available for inspection on the Trust website or from the Trust Secretary (01392 404551).

Elections to the Council of Governors 2021

A proposal regarding the 2021 CoG elections was discussed at the June 2021 CoG meeting. Following the discussion, a further proposal was developed and shared with the CoG, which gave its majority approval for the Trust to proceed with the election. The agreed proposal meant that the 2021 election included 12 posts as follows:

- **East Devon, Dorset, Somerset, Rest of England** – 3 posts.
- **Exeter and South Devon** – 3 posts.
- **Mid, North, West Devon and Cornwall** – 2 posts.
- **Staff** – 4 posts.

It was agreed that three current vacant posts (one in each public constituency area) would not be included in the 2021 election in order to provide flexibility in regard to the 2022 elections and with any posts created under the revised Constitution for the proposed new organisation should the integration with NDHT go ahead.

Uncontested election – Exeter and South Devon.

With three candidates for three posts, an uncontested election was declared. Janet Bush and Hugh Wilkins received terms of two years with Elizabeth Witt receiving a three-year term. The length of term of office was decided by the drawing of lots by the Returning Officer at UK Engage, the election services company.

Contested elections

With more candidates than posts available, contested elections were held as follows:

East Devon, Dorset & Somerset and the Rest of England

There were eight candidates for three posts. Kay Foster and Barbara Sweeney were re-elected and Heather Penwarden was newly elected, all for two-year terms. The turnout was 23.48% (for comparison it was 23.56% in 2019). Bob Maskell, who stood for re-election, was unsuccessful.

Mid North West Devon & Cornwall

There were three candidates for two posts. James Bradley was re-elected for a term of three years with Annie Adcock newly elected for a term of two years. Turnout was 20.17% (20.01% in 2019). Marcus Pipe, who stood for re-election, was unsuccessful.

Staff

There were nine candidates for four posts. Anum Shuja was re-elected for a term of three years with Hazel Hedicker re-elected for a term of two years. Mascia Checconi and Simon Leepile were newly elected for terms of two years. Turnout was 10.27% (10.78% in 2019). Catherine Geddes and Dominic Hazell stood for re-election and were not successful.

The differing terms of office included in the election were as a result of no elections being held in 2020 due to the pandemic and the Trust using flexibility afforded to it by the Constitution to offer terms shorter than the usual three years in order to achieve a routine cycle of elections in 2023.

Summary of attendance of Governors at CoG meetings for 2021/22

P = Public C = Confidential Name of Governor	May 21	Jun 21		Aug 21		Sept 21		Oct 21	Nov 21		Feb 22		Mar 22
	11th	7th		20th		12th	29th	12th	29th		28th		23rd
	C	P	C	P	C	C	AMM	C	P	C	P	C	C
Adcock, Annie							P	P	P	P	P	P	P
Biggar, Rob	P	P	P	A	A	A	A	P	P	P	P	P	A
Bradley, James	A	P	P	P	P	A	P	P	P	P	P	P	A
Bush, Janet							P	A	P	P	P	P	P
Checconi, Massia							P	P					
Doris, Faye	P	P	P	P	P	P	P	P	A	A	P	P	P
Ducker, Tony	P	P	P	P	P	A	A						
Flatters, Peter	P	A	A	P	P	A	P	P	P	P	P	P	P
Foster, Kay	P	P		P	P	P	P	P	P	P	P	P	P
Foxall, Peta	P	P	P	P	P	P	P	P	P	P	P	P	P
Geddes, Catherine	A	P	P	P	P	A	A						
Goodall, Olwyn	A	P	P	P	P	P	P	P	P	P	P	P	A
Hall, Ian				A	A	P	P	A	A	A	P	P	P
Hazell, Dominic	P	P	P	P	A	P	A						
Hedicker, Hazel	P	P	P	P	P	P	P	P	P	P	P	P	P
Herpoldt-Bright, Monika	P	P	A	P	P	P	P	P	P	P	A	A	A
Kumar, Desmond	A	A	A	P	P	P	A	A	P	P	A	A	A
Leepile, Simon							P	P	P	P	P	P	P
Maskell, Bob	P	P	P	P	P	P	P						
Noar, Rachel	A	P	P	A	A	P	P	P	A	P	A	A	P
Penwarden, Heather							P	P	P	P	A	A	P
Pipe, Marcus	P	P	P	P	P	P	A						
Shore, Angela	P	P	A	A	A	A	A	P	P	P	P	A	P
Shuja, Anum	P	P	P	P	P	P	A	P	P	P	P	A	P
Sweeney, Barbara	P	P	P	A	A	A	P	P	P	P	P	P	P
Wilkins, Hugh							P	P	P	P	P	P	P
Wilkinson, Tony	P	P	P	P	P	P	A	P	P	P			
Witt, Elizabeth							P	P	P	P	P	P	P
James Brent, Chairman	P	P	P	P	P	n/a	P	P	P	P	P	P	P

Present	P
Apologies	A
Did Not Attend	DNA
Not in post	

Voluntary Disclosures

Equality report

The Trust Board of Directors view equality, diversity and inclusion as central to their view of the Trust being an employer of choice, recognising that staff who feel included are happier, deliver better care to patients and bring innovation to the Trust. The Trust Chief Executive Officer leads on the inclusion plans with the support of the Chief People Officer and the wider People Function.

The Trust recognises the importance of taking a system approach to inclusion and have been working closely with local partners to achieve this, including shared inclusion events and recruitment where appropriate. This has resulted in creating an environment of learning and shared techniques to eliminate discrimination and allow our people to flourish.

Throughout the year significant work has taken place on inclusion whilst ensuring accountability and tracking through governance, as well as listening to soft intelligence provided through various staff networks and groups.

Workforce Race Equality (WRES) Report

The Workforce Race Equality Standard (WRES) was first introduced in 2016 and requires Trusts to compile and submit a standard national report in order to demonstrate its findings and to demonstrate progress against a number of indicators relating to the representation of Black and Minority Ethnic staff.

The WRES is in place to ensure that employees from Black and Minority Ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and aims to highlight any differences between the experience and treatment of white staff and Black and Minority Ethnic staff in the NHS. This is completed with a view to closing any identified gaps through the development and implementation of action plans, focused upon continuous improvement over time.

The Trust publishes a summary of its annual WRES data, which can be found here, but of note is the improvement of the data held that will allow the Trust to have a better understanding of the experiences of our people. The data has indicated some notable data quality improvements this year as well as a statistically significant decrease in the percentage of Black and Minority Ethnic staff experiencing harassment, bullying or abuse. This is however offset by a concerning increase in the percentage of Black and Minority Ethnic staff who have experienced discrimination from manager / team leader or other colleagues in last 12 months.

The total number of staff employed by the RD&E at 31st March 2021 stood at 9191, of which 761 were recorded as Black or Minority Ethnic. Based on these figures, Black and Minority Ethnic staff represent 8.3% of the total staff population.

According to the data the percentage of Black and Minority Ethnic staff employed by the Trust has increased by 2.5% (from 5.8%) from the previous reporting period ending March 2020; however, this is likely to have been as a result of improved data quality with a very large reduction in the number of employees having a recorded ethnicity of Ethnicity Unknown/Null. This number has reduced from 1275 staff to 427 and the data confirms that 95.4% of staff now have their ethnicity recorded in ESR.

Workforce Disability Equality (WDES) Report

The Workforce Disability Equality Standards (WDES) was first introduced in 2019 and requires Trusts to compile and submit a standardised national report of its findings and to demonstrate performance against a number of indicators relating to workforce disability equality, including a specific indicator to address the low levels of representation for staff with disabilities at Board level. The Trust publishes a summary of its annual WDES data, which can be found here.

The WDES should ensure that employees who have a disability have equal access to career opportunities, receive fair treatment in the workplace and aims to highlight any differences between the experience and treatment of those who identify as having a disability versus those who do not. This is completed with a view to closing any identified gaps through the development and implementation of action plans focused upon continuous improvement over time.

The total number of staff employed by the RD&E at 31st March 2021 stood at 9191 of which 298 were recorded as having a disability and 2615 with an unknown status recorded on ESR. The total headcount and number of staff who are recorded as having a disability have both slightly increased from last year.

Whilst the number of staff with an unknown disability status has slightly decreased, only 71.55% of staff have their disability status recorded on ESR. According to ESR information, staff with a disability represent 3.24% of the total staff population. This is a slight increase from the 2.97% of the total staff population recorded last year. It should be noted that for new starters, the employee's disability status is transferred from their NHS jobs application and automatically added to ESR so the percentage of staff with a disability status recorded should increase as new recruits join the organisation.

The data has shown that of the 144 people shortlisted, who classified themselves as disabled, 47 of these were appointed. This means that 33% were taken into employment, an increase of around 12% from last year. 24% of people who identify as not disabled were appointed into roles.

This demonstrates that based on the recruitment activity recorded in this period, those who identify as having a disability are significantly more likely to be appointed from shortlisting than those who do not.

Gender pay gap

From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings. The Trust publishes a summary of its annual gender pay gap data, which can be found here.

It should be noted that no bonuses are paid within the Trust as part of pay packages; however, for the purposes of the Gender Pay Gap report, Advisory Committee on Clinical Excellence Awards (ACCEA) payments, part of a national scheme are classified as a bonus.

Other than for medical and dental staff (doctors and dentists), some Apprentices, Non-Executive Directors and Very Senior Managers, all other jobs are evaluated using the national Agenda for Change (AfC) job evaluation scheme. This process evaluates the job and not the post holder and makes no reference to gender or any other personal characteristics of existing or potential job holders. VSM's include Executive Directors and a small number of other senior posts.

The Trust performance against the relevant national benchmarks continues to be respectable overall. The headline gender pay gap is smaller than the median national average and also lower than both median and mean averages of industry sectors.

Women's hourly rate is:	
22.2% LOWER (mean)	**9.3%** LOWER (median)
Pay quartiles:	
How many men and women are in each quarter of the employer's payroll.	
Top quartile	
31.5% MEN	**68.5%** WOMEN
Upper middle quartile	
17.7% MEN	**82.3%** WOMEN
Lower middle quartile	
22.1% MEN	**77.9%** WOMEN
Lower quartile	
19.9% MEN	**80.1%** WOMEN
Women's bonus pay is:	
45.4% LOWER (mean)	**34.9%** LOWER (median)
Who received bonus pay:	
4.8% OF MEN	**0.5%** OF WOMEN

Due to issues within the ACCEA system for consultants, gender inequality is greater than would be expected against any national benchmark measure relating to the mean average, or payment of bonuses. There is an action plan to counteract this both at a national and local level and the Trust expects to see improvements continuing for the year ahead.

There is much work to be done still when looking at the experiences of staff in the Trust from a range of backgrounds and demographics and there needs to be a real focus on intersectionality. With the new Inclusion Lead in post and a new senior leadership structure in the People Function looking at the holistic experience of our people, the Trust is positive about the direction it is heading.

Modern Slavery Act 2015

In accordance with the Modern Slavery Act 2015, the Royal Devon University NHS Foundation Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and makes the following statement regarding the steps it is taking to ensure that modern slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains.

The Home Office's Statutory Guidance on Modern Slavery (2021) is intended for staff in England and Wales within public authorities who may encounter potential victims of modern slavery and/or who are involved in supporting victims. The Home Office states that these individuals and organisations must have regard to the Statutory Guidance, with a view

to developing a more consistent response to modern slavery victims to ensure they are identified and receive the available and appropriate support.

The process of identification can be very challenging, in particular establishing the means and purpose of activities and differentiating, in terms of the Act, those adults who are subject to poor or illegal work conditions and those who are victims of Modern Slavery through the use of force, control, deception and threat. Tackling Modern Slavery and Human Trafficking requires a collective, co-ordinated and sustained effort from a range of collaborating agencies, both statutory and non-statutory. No single agency or individual can eradicate Modern Slavery alone and this effective partnership working is essential.

The Trust's position on Modern Slavery is to:

- Develop an awareness of human trafficking and modern slavery within our Workforce and provide them with information and support to act appropriately to identify, support and refer victims.
- Comply with legislation and regulatory requirements.
- We are committed to ensuring that there is no Modern Slavery or Human Trafficking in any part of our business and, insofar as is possible, to requiring our suppliers to hold a corresponding ethos and make suppliers and service providers aware that we promote the requirements of the legislation.

Slavery and human trafficking statement for financial year 2021/2022

During the last financial year the Trust took, and continues to take, the following:

- The Trust is a key partner in in the development of the Devon and Torbay Modern Slavery Adult Victims Referral/Support Pathway Protocol Anti-Slavery Partnership and is a signatory to this document. The Trust has adopted the Quick Guide to assist and enable Staff to act appropriately in support of victims.
- The Trust has a number of controls in place to ensure compliance with employment legislation:
    - We confirm the identities of all new employees and their right to work in the United Kingdom.
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence their duties, that they have a legal right to work within our Trust.
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process.
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015.
- Our Equality and Diversity, Grievance and Prevention of Harassment & Bullying policies additionally give a platform for our employees to raise concerns about poor working practices.
- Our policies and practices promote and support diversity and inclusion both as an employer and as a service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since 2017.
- Modern slavery is incorporated within our mandatory Safeguarding Children and Adults training from levels 1-3, which applies to all staff and Safeguarding Policies. Our Trust "Safeguarding Adult Policy", and the Devon Multi-Agency Safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery. Our Trust intranet site includes information and support which sign posts to the Modern Slavery helpline and website for further information. We also share information via our Safeguarding newsletter to raise awareness.
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff

Working with suppliers

- In addition, all other external agencies providing staff to the Trust have been approved through Government Procurement Suppliers (GPS). The Trust will audit and monitor agencies (via GPS) that provide staff once a year to ensure that they are able to provide evidence of identification, qualification and registration.
- Our standard terms and conditions require suppliers to comply with relevant legislation. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts which also require suppliers to comply with relevant legislation.

The Trust follows best practice guidance and works with multi agency partnerships to meet the regularity and statutory requirements of the Act and Code of Practice ensuring all reasonable steps are taken to prevent slavery and human trafficking and will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation.

Sustainability Report

In January 2020, the campaign for a Greener NHS was launched to mobilise more than 1.3 million staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero by 2040[1].

To support this, the RD&E and NDHT have developed a Joint Green Plan, which sets out how the merging Trusts plan to go about achieving their long-term sustainability goals and 'Net Zero' targets. The Green Plan will act as a sustainability guide to the design and implementation of our future services and will act as a strong foundation to ensure that the environmental ambitions are embedded into everything we do.

The Green Plan, which was signed off by the RD&E and NDHT's Board at the end of January 2022, must now be delivered across the merged Trust. This plan sets out the communication and engagement objectives, approach, key messages, timeline for delivery, and outputs required to support the plan's delivery. The Green Plan delivery is being led by the Deputy Chief Executive and the Director of Business, Innovation and Sustainability and supported by a core team of staff with environmental skills and experience.

Sustainability initiatives will be driven by our operational departments and will complement this plan through alignment of their key messages, objectives and approach. This plan has been developed at a time where the RD&E and NDHT were working closely together as part of their proposed integration. As such, all objectives, communications and engagement activity will be delivered across the newly formed Trust in an aligned way but recognising where local differences exist.

The sustainability section of the Annual Report will detail progress against the Green Plan, and at a minimum, include the mandatory reporting requirements as required by NHSE/I's Greener NHS team. The scope of this report is to capture performance over the last year of the RD&E's activities.

[1] And by 2045 net zero for the NHS footprint including all emissions influenced but not directly controlled by the service.

Our sustainability targets:

In our Green Plan there are three overarching strategic targets with supporting objectives:

1. Embody sustainable healthcare

Prioritising sustainability objectives in order to make sustainable healthcare a business as usual activity.

2. Staff engagement

Our ability to deliver on this ambitious Green Plan will be dependent upon all parts of the organisation pulling together as one team. Whilst the Sustainability Steering group will have co-ordination and assurance roles, it will be the actions of our thousands of staff members that will make the plan impactful.

3. Carbon reduction

The table below shows the elements that make up NHS carbon emissions – the carbon "footprint".

"NHS Carbon Footprint" includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics, inhalers and business travel.

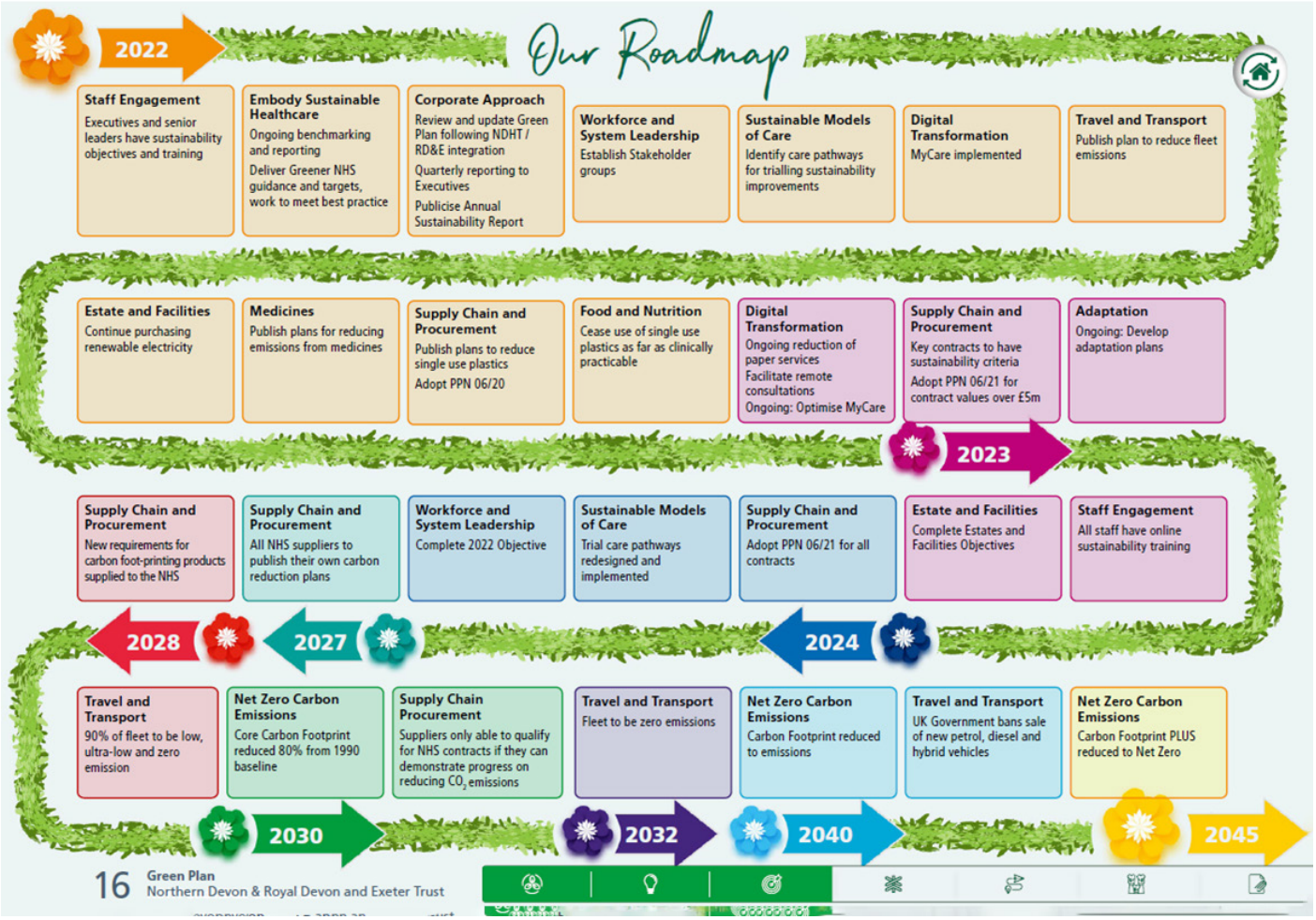
"The NHS Footprint PLUS" includes the emissions associated with products and services that we purchase."

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, we are committed to the following carbon targets:

Objective	Progress
Carbon Footprint: • Reduced 80% by 2030 (against 1990 baseline) • Net Zero Carbon by 2040	Various consumption reduction projects are underway, with details in the specific areas below.
Carbon Footprint PLUS: Net Zero Carbon by 2045	
Establish methods to: Quantify, measure, monitor and reduce CO2 emissions	

Our Net Zero roadmap

Our plan establishes a series of work initiatives that are designed to make progress on these 3 strategic targets and their supporting objectives. These, and key deadlines, are shown pictorially via a Road-Map – see the diagram below:



NHSE/I have developed several "Key Areas of Focus" that the NHS is required to target, in order to reduce carbon emissions, costs and improve our impact on people and the environment. These are embedded in the Road-Map as shown in the diagram above.

Key Areas of Focus: Achievements in 2021/2022:

Workforce and system leadership

- Supporting staff to improve sustainability at work and home
- Enabling staff to adopt sustainable practices and take ownership
- Sustainability leadership in our communities; across our supply chain and beyond.

"Greener NHS" mural painted by staff and visitors and recorded via time-lapse video

Green Team Projects

As part of our continuing efforts to empower staff to make sustainable changes across the organisation, we have continued to champion green team projects. Our Theatres team have formed a Green Team to investigate reusable theatre caps and improve waste management, both of which are led by clinical colleagues and supported by the Sustainability team. Significant progress with the Theatre Caps project has been made in 2021/2022 and we are reaching a point where the evidence base will enable us to procure a more sustainable solution during 2022/2023.

Evaluation and improvement plans have been completed to help improve waste management and implementation due to take place in the coming months.

Staff from our Green Theatres Re-usable Theatre Cap Project at RD&E Wonford

Sustainable models of care

- **Deliver the best quality of care while being mindful of its social, environmental and financial impact.**
- **Improve the environmental sustainability of care pathways and better integrate healthcare services to improve efficiency.**

Green ED

Our Emergency Department (ED) has been part of a nationwide pilot called "Green ED", looking to address sustainability in emergency medicine. Using a Bronze/Silver/Gold matrix to track progress across different areas of impact, the team, led by Dr Steve Fordham, have made great progress in reducing their carbon footprint. Measures include rationalising radiology and pathology investigations to reduce waste, reducing the use of Entonox (an anaesthetic gas) by 60% compared to baseline and going paperless as part of the MyCare system implementation.

Digital transformation

- **Be digitally optimised with connected care that is patient accessible**
- **Promote efficiency and maximise productivity**
- **Support innovative working**

Digital Innovation

As a result of both the implementation of Epic (our electronic patient record) and the COVID-19 Pandemic, digital innovation and new ways of working have accelerated. This includes a reduction in business mileage as a result of agile working, as well as fewer patient miles travelled through e-consultations and teleconsultations. A shift to paperless working has enabled a 23% reduction in paper in 2 years, or the equivalent of 2.35 million sheets of paper.

Travel and transport

- **Increase use of sustainable and active modes of travel that deliver environmental and health benefits**
- **Minimise the environmental and health impacts associated with movement of goods and people through Trust activity.**

Active Travel

More secure cycle shelters have been installed in the past year, accessible via staff ID badges. A new Travel Permit has opened up the use of these cycle shelters to all staff. An additional 10 bike lockers have been installed at Digby Park and Ride to support staff looking to park and cycle. We also continue to promote the Cycle to Work scheme as well as the utility of our Park and Ride facility. Staff in the Exeter area can also benefit from shared transport options such as Co-Bikes, accessible from both Wonford and Heavitree sites.

Bikes at RD&E Wonford, photo taken during a recent cycle audit (March 2022)

Estates and facilities

- **Reduce environmental impact of building works during the design, refurbishment, construction, operation and decommissioning stages**
- **Embed energy and water efficient technologies and practices throughout our Estate and services, delivering year on year reductions in consumption.**

Energy Performance Contact

Our energy performance contract in partnership with Centrica continues to help us deliver on our commitment to reduce our Carbon Dioxide (CO2e) from energy, waste and water by 28% against a 2013 baseline. The overall project has resulted in a reduction in annual CO2e emissions of 2,200 tonnes. This has delivered an annual saving of £800,000. We are now working with Centrica to look at what further improvements can be made to further accelerate our energy decarbonisation in 2022/2023.

Medicines

- **Reduce CO2 emissions associated with areas of high impact such as pharmaceuticals and anaesthetic gases.**

Sustainable anaesthesia

There are ongoing efforts to eliminate the carbon-intensive anaesthetic gas Nitrous Oxide from a wide range of clinical area, led by Dr Pete Ford (Clinical Director for Business Innovation and Sustainability). These include the successful disconnection of all non-maternity Anaesthetic machines from the Nitrous Oxide (N2O) pipeline and a move in the Emergency Department (ED) to Penthrox for adult sedation saving 1000L of N2O per week

Supply chain and procurement

- **A step change in education and awareness of sustainability best practices across Trust service delivery staff involved in procuring goods and services.**
- **Move to sustainable procurement approaches.**
- **Minimise unnecessary procurement and resource use.**

Sustainable Procurement

Our procurement team is developing a plan to implement new mandatory requirements to consider Social Value and carbon reduction in tendering. This builds on our staff engagement work such as the Reusable Theatre Hats Green Team project which is acting as a test bed for sustainable procurement initiatives, led by clinical staff and supported through our Procurement team.

Food and nutrition

- **Reduce CO2 emissions from food made, processed or served within the organisation**
- **Ensure food is from sustainable sources**

Catering Exemplar Group

Following on from a successful Green Team project, our catering team have spearheaded new sustainable practices over the past couple of years. These include a continued commitment to the reduction of single-use plastics, buying from suppliers within a 50-mile radius as well as an increase in the offer of plant-based meals through our catering outlets. They have also been part of a UK wide 'Exemplar' group that follows on from the Hospital Food Review in 2020. This group aims to share best practise and support the implementation of a wide range of sustainable food objectives, including the reduction in food waste, promotion of plant-based food and a focus on local producers.

Adaptation

- **Ensure our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts of climate change.**
- **Reduce the impact on public health from climate change.**

Biodiversity and Outdoor Wellbeing Action Plan

RD&E Apprentices planting bulbs in October 2021

Working alongside the RSPB, we have produced a Biodiversity and Outdoor Wellbeing Action Plan (BOWAP) the aims to bolster the biodiversity value of our existing greenspace and inform new planning and building projects to ensure we are promoting good environmental stewardship of our sites. We have created over 200m2 of Wildflower and 'No Mow' habitat and are working with community colleagues to develop greenspace across the Trust – both for wellbeing and nature.

Natural resource consumption

Energy:

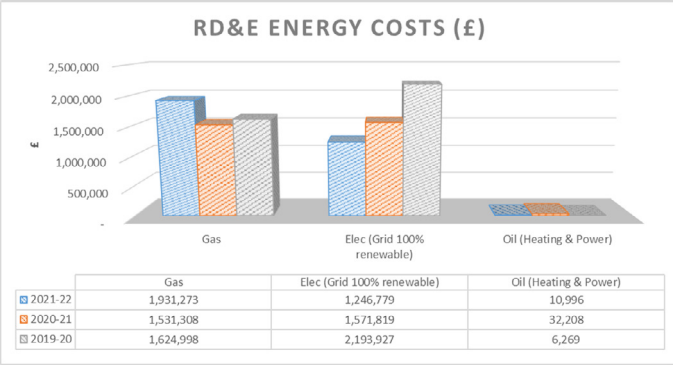
Over the last few years energy use at the RD&E has changed dramatically. Usage patterns have changed in response to COVID-19 the extra heating required in response to increasing ventilation is estimated to have cost the Trust £68,000 in 2020-21. Over £8m has been invested in various measures across the estate to reduce the demand for energy at point of use, but increases in activity keep pushing overall consumption up. Measures included solar panels, LED lighting and automated controls on air conditioning. A new gas-powered Combined Heat and Power (CHP) engine has also been purchased, the Trust now has two units generating 2.5MW of electricity. The new CHP will increase the amount of natural gas being used but reduce the amount of grid electricity being purchased. This is to deliver more efficient generation of heat and power.

In line with NHS requirements, all purchased grid electricity is certified 100% renewable.

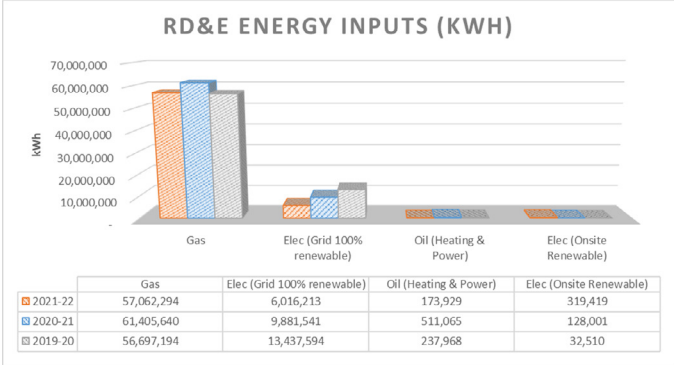
Oil is no longer in use as a primary fuel on any site. Oil is required as back up fuel in emergency generators that require regular testing, so there is residual usage.

The Trust is continuing to invest in demand reduction measures and is developing a plan to decarbonise building energy in line with Greener NHS targets.

The chart below shows a slight decline in gas usage in 2021-22, this is due to one of the CHP units being offline for most of the year.



	Gas	Elec (Grid 100% renewable)	Oil (Heating & Power)
2021-22	1,931,273	1,246,779	10,996
2020-21	1,531,308	1,571,819	32,208
2019-20	1,624,998	2,193,927	6,269



	Gas	Elec (Grid 100% renewable)	Oil (Heating & Power)	Elec (Onsite Renewable)
2021-22	57,062,294	6,016,213	173,929	319,419
2020-21	61,405,640	9,881,541	511,065	128,001
2019-20	56,697,194	13,437,594	237,968	32,510

Carbon Dioxide (CO2) emissions reduction

The Trust has committed to meeting National net-zero CO2 reduction targets and has focused efforts on delivery of demand reduction projects. We are now working to better understand CO2 emission reporting for the trust as a whole, to include procurement, travel and other aspects. A new reporting format will be produced when the Greener NHS team release guidance on this later in 2022. The table below shows performance against the base year. The majority of building CO2 emission reduction has been driven by demand reduction projects and the decarbonisation of the National Grid. There is a trend towards a reduction in carbon emissions against our 2013 baseline as a result of a combination of interventions including the Energy Performance Contract, grid decarbonisation and a reduction in demand due to COVID-19. These figures are also reported via the Estates Return Information Collection (ERIC) and through the UK Emissions Trading Scheme (UK ETS).

Reporting Scope- as per Greenhouse Gas emission Protocol		2013 Baseline			Carbon Emissions (tCO2e)		
		Consumption		tCO2e	2019/20	2020/21	2021-22
Scope 1/3	Gas	45,216,722	kWh	9,592	11,880	12,759	12,240
	Oil	3,122,047	kWh	1,085	39	122	39
Scope 2/3	Electricity	20,764,290	kWh	11,626	3,726	2,502	1,390
Scope 3	Waste	1959	t	479	289	258	258

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

ANNUAL ACCOUNTS

YEAR ENDED 31 MARCH 2022

INDEX

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST - ANNUAL ACCOUNTS 2021/22

Statement of the Chief Executive's responsibilities as the Accounting Officer of the Royal Devon and Exeter NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which require the Royal Devon and Exeter 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 the Royal Devon and Exeter NHS Foundation Trust and of its income and expenditure, 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; and

- prepare 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 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 Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Signed:

Date: 8 June 2022

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST (FORMERLY KNOWN AS ROYAL DEVON AND EXETER NHS FOUNDATION TRUST)

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Royal Devon and Exeter NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2022 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we do not believe there is a fraud risk related to revenue recognition because of the non-complex recognition due to the nature of the revenue, which limits the opportunities to fraudulently misstate revenue.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to non-pay and non-depreciation expenditure recognition, particularly in relation to year-end accruals.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation, such as unexpected account pairings with revenue and borrowings.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias
- Inspecting cash payments and purchase invoices in the period prior to 31 March 2022 to verify expenditure had been recognised in the correct accounting period.
- Evaluating a sample of accruals posted as at 31 March 2022 and verifying accruals posted as at 31 March 2022 are appropriate and accurately recorded.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion those reports have been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take, or has taken, 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 this respect.

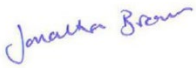
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone

other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Royal Devon and Exeter NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

16 June 2022

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2022 have been prepared by the Royal Devon and Exeter NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed:

Date: 8 June 2022

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2022

	Note	2021/22 £000	2020/21 £000
Income from activities	3	**594,203**	511,421
Other operating income	4	**102,734**	145,331
Operating income		**696,937**	656,752
Operating expenses	5	**(691,784)**	(667,820)
Operating surplus / (deficit)		**5,153**	(11,068)
Finance costs			
Finance income	10	**32**	20
Finance expense	11	**(2,601)**	(756)
PDC dividends payable		**(6,945)**	(4,289)
Net finance costs		**(9,514)**	(5,025)
Other gains	12	**14**	9
Deficit for the year		**(4,347)**	(16,084)
Other comprehensive income			
Revaluation gains on property, plant and equipment	16.3	**1,054**	9,468
Total comprehensive (deficit) for the year		**(3,293)**	(6,616)

The Trust's deficits for the years 2021/22 and 2020/21 both include transactions relating to impairment charges of £9.8m in 2021/22 (£18.6m in 2020/21). The Annual Report provides further details of the 2021/22 impairment.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	15	**37,255**	42,135
Property, plant and equipment	16	**299,231**	270,474
Investment in joint venture	17	**5**	5
Trade and other receivables	19	**1,954**	2,595
Total non-current assets		**338,445**	315,209
Current assets			
Inventories	18	**10,231**	10,801
Trade and other receivables	19	**36,977**	24,405
Cash and cash equivalents	23	**68,575**	63,543
Total current assets		**115,783**	98,749
Current liabilities			
Trade and other payables	20	**(74,077)**	(69,657)
Borrowings	21	**(6,277)**	(6,029)
Provisions	22	**(191)**	(372)
Other liabilities	20	**(14,083)**	(9,009)
Total current liabilities		**(94,628)**	(85,067)
Total assets less current liabilities		**359,600**	328,891
Non-current liabilities			
Borrowings	21	**(63,038)**	(66,132)
Provisions	22	**(919)**	(1,617)
Other liabilities	20	**(1,877)**	(1,959)
Total non-current liabilities		**(65,834)**	(69,708)
Total assets employed		**293,766**	259,183
Financed by taxpayers' equity			
Public dividend capital		**231,681**	193,805
Revaluation reserve		**40,342**	40,342
Income and expenditure reserve		**21,743**	25,036
Total taxpayers' equity		**293,766**	259,183

The notes on pages 13 to 35 form part of these accounts.

The Annual Accounts on pages 9 to 35 were approved by the Board of Directors on 8 June 2022 and signed on its behalf by :

Date: 8 June 2022

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	**Total**
	£000	£000	£000	**£000**
Taxpayers' equity at 1 April 2020	161,055	30,874	41,120	**233,049**
Deficit for the year	-	-	(16,084)	**(16,084)**
Revaluations - land and buildings	-	9,468	-	**9,468**
Public dividend capital received	32,750	-	-	**32,750**
Taxpayers' equity at 31 March and 1 April 2021	193,805	40,342	25,036	**259,183**
Deficit for the year	-	-	(4,347)	**(4,347)**
Revaluations - land and buildings	-	1,054	-	**1,054**
Other reserve movements	-	(1,054)	1,054	**-**
Public dividend capital received	37,876	-	-	**37,876**
Taxpayers' equity at 31 March 2022	**231,681**	**40,342**	**21,743**	**293,766**

Public dividend capital ("PDC")
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. It also includes additional PDC issued 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 and Social Care as a public dividend capital dividend. PDC has no fixed capital repayment period.

Revaluation reserve
The reserve reflects movements in the value of purchased property, plant and equipment and intangible assets as set out in the accounting policies.

Income and expenditure reserve
The reserve is the cumulative surplus / (deficit) made by the Trust since its inception. The reserve cannot be released to the Statement of Comprehensive Income.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**5,153**	(11,068)
Non-cash income and expense			
Depreciation and amortisation		**20,956**	12,959
Impairments		**9,776**	18,594
(Increase) / decrease in trade and other receivables		**(12,223)**	9,966
Decrease / (increase) in inventories		**570**	(2,092)
Increase in trade and other payables		**360**	10,784
Increase in other liabilities		**4,992**	3,757
(Decrease) / increase in provisions		**(875)**	202
Income recognised in respect of capital donations		**(173)**	(2,249)
Net cash generated from operations		**28,536**	40,853
Cash flows from investing activities			
Interest received		**32**	20
Purchase of intangible assets		**(1,096)**	(25,535)
Purchase of property, plant and equipment		**(51,042)**	(44,536)
Sale of property, plant and equipment		**2,333**	23
Receipt of cash donations to purchase capital assets		**173**	110
Net cash used in investing activities		**(49,600)**	(69,918)
Cash flows from financing activities			
PDC received		**37,876**	32,750
Loans received		**1,617**	10,584
Loans repaid		**(4,850)**	(3,014)
Capital element of finance lease rental payments		**(172)**	-
Interest paid		**(2,047)**	(2,125)
PDC dividend paid		**(6,328)**	(3,668)
Net cash used in financing activities		**26,096**	34,527
Increase in cash and cash equivalents		**5,032**	5,462
Cash and cash equivalents at 1 April		**63,543**	58,081
Cash and cash equivalents at 31 March	23	**68,575**	63,543

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

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 the accounts.

Accounting convention

The 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 liabilities at their value to the business by reference to their fair value.

Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

International Accounting Standard 1 (IAS 1) requires the Board to assess, as part of the accounts 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 the transfer of its services to another entity within the public sector.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

On 1 April 2022 the Trust acquired the assets and business of Northern Devon Healthcare Trust through merger by acquisition.

The Trust has produced a financial plan for 2022/23 and has prepared a cashflow forecast to the end of June 2023. From the financial modelling undertaken the Trust is expecting to have sufficient cash to cover its requirements for this period.

It is noted that the cash regime within the NHS for new financial revenue support will be in the form of non-repayable Public Dividend Capital, rather than interest bearing loans. Therefore, should the Trust be in need of cash support it will not be in the form of repayable debt.

Based on the factors outlined above, the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval of the financial statements and fulfil any liabilities as they fall due. The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

1.1 Income recognition

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.

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.1 Income recognition (continued)

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15.

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Sustainability and Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. 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 also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, 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.

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

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, less the fair value of the asset.

1.2 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

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a 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.

1.3 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Intangible assets

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.

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year and have a cost of at least £5,000.

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 where it meets the requirements set out in IAS 38.

Measurement and revaluation

Intangible assets are recognised initially 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 intended by management.

The fair value of intangible assets is determined where necessary by a valuation undertaken by a professionally qualified independent valuer. Valuations are carried out primarily on the basis of depreciated replacement cost, where the asset is a non-cash generating asset. The frequency of the revaluation is dependent on the change in the fair value of the intangible asset. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment (see note 1.5).

Amortisation and impairment

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The carrying value of intangible assets is reviewed for impairment if events or changes in circumstances indicate the carrying value may not be recoverable.

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.

Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful lives.

Asset category	Useful life (years)
Software licences	3 - 15

Research and development

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Intangible assets (continued)

Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred.

Where possible the Trust will disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Other property, plant and equipment assets acquired for use in research and development are amortised over the life of the associated project.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment are 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 and;
- has an individual cost of at least £5,000; or
- the items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up costs of a new building or on refurbishment, may also be "grouped" for capitalisation purposes.

Measurement and revaluation

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 fair value.

Property assets

The fair value of land and buildings is determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property based upon providing a modern equivalent asset. Existing use value is used for non-specialised operational property. For non-operational properties, including surplus land, the valuations are carried out at open market value. The frequency of revaluation is dependent upon changes in the fair value of property assets however, in line with NHS Improvement's view, the frequency of property asset revaluations will be at least every five years. Note 16.3 provides details of the most recent valuation which was undertaken.

Buildings with a number of components that have significantly different asset lives, e.g. fixed plant are depreciated over the useful economic life of the component.

Assets under construction are valued at cost and may subsequently be revalued by professional valuers when brought into use or when factors indicate that the value of the asset differs materially from its carrying value.

Non-property assets

For non-property assets the depreciated historical cost basis has been adopted as a proxy fair value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been brought into operation, such as repairs and maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from the use of an item of property, plant and equipment, and where the cost of an item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Property, plant and equipment (continued)

Depreciation

Items of property, plant and equipment are depreciated on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives are determined on a case by case basis. The typical lives for the following assets are:

Asset category	Useful life (years)
Freehold property - buildings	14 - 45
Freehold property - dwellings	19
Plant and machinery	4 - 21
Equipment - transport	5 - 8
Equipment - information technology	3 - 11
Equipment - furniture and fittings	5 - 10

Freehold land is considered to have an infinite life and is not depreciated.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

The excess depreciation on revalued assets over the historical cost is released to the income and expenditure reserve. On disposal of an asset any remaining revaluation reserve balance is released to the income and expenditure reserve.

Impairment

The carrying values of property, plant and equipment assets are reviewed for impairment when events or changes in circumstances indicate their carrying value may not be recoverable.

Decreases in asset values that are due to a loss of economic benefits or 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 which is 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.

Increases in asset values arising from revaluation are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, such reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have been if the original impairment had never been recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income.

1.6 Donated, government grant and other 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.

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.

1.7 Inventories and work in progress

Inventories and work in progress are valued at the lower of cost and net realisable value. Cost is determined using a first in, first out method.

Work in progress comprises goods in intermediate stages of production.

Provision is made where necessary for obsolete, slow moving and defective inventories and work in progress.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.7 Inventories and work in progress (continued)

In 2020/21 and 2021/22, the Trust received 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.

1.8 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of where 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 required to settle the obligation. The Trust uses HM Treasury's pension rate of -1.30% (2020/21 -0.95%), in real terms, as the discount rate for early retirement and injury benefit provisions.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution, 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 22, but this value 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.

1.9 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Contingent liabilities

The Trust has contingent liabilities in respect of NHS Resolution legal claims arising in the normal course of activities. Where the transfer of economic liabilities in respect of legal claims is possible the Trust discloses the estimated value as a contingent liability in note 25.

1.11 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, they are disclosed in a separate note, note 28, to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.12 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed regulation. By their nature they are items that ideally should not arise. They are therefore subject to specific control procedures compared with the generality of payments. They are divided into different categories, which govern the way the individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.13 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.13 Critical accounting estimates and judgements (continued)

Accounting judgement - Modern Equivalent Asset valuation

The majority of the Trust's estate is considered to be specialised assets as there is no open market for an acute hospital. The modern equivalent asset valuation is based on the assumption that any modern equivalent replacement hospital would be built on an alternative site within the Exeter locality.

Accounting judgement - Intangible Asset valuation

The intangible asset relating to the Health Record System was valued on a depreciated replacement cost basis in 2020/21 when it was brought into use.

Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.14 Leases

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 charge 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

Where leases are regarded as operating leases the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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.

1.15 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 trust, the Royal Devon and Exeter Healthcare NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over 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.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and the average daily cash held with the Government Banking Service. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets in the pre-audit version of the accounts after adjusting for the average daily cash held within the Government Banking Service. The dividend charge would not be revised should any adjustments to net assets occur as a result of any changes between the draft and audited accounts.

1.16 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All 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 derecognised when the obligation is discharged, cancelled or expires.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Financial instruments and financial liabilities (continued)

Classification and measurement

Financial assets are categorised as 'loans and receivables'. Financial liabilities are classified as 'other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the statement of financial position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.17 Corporation tax

The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of an NHS foundation trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, the FT is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the exemption is dis-applied then the FT has no corporation tax liability.

1.18 Consolidation of NHS charitable funds

The Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity. The Charity has not been consolidated within these annual accounts as the value of the Charity is low and consolidation into the Trust's accounts would have no material effect. Further information relating to transactions between the Trust and the Charity is disclosed in note 26.

1.19 Interests in other entities

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.20 Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised as a transfer by absorption within the Statement of Comprehensive Income, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Adjustments to align the acquired assets / liabilities to the foundation trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

2. Segmental analysis

The Chief Operating Decision Maker, who is responsible for the allocation of resources and the assessment of the performance of operating segments has been identified as the Trust's Board of Directors.

Throughout the financial year the Trust's Board of Directors received a monthly integrated performance report, that provided information against key standards and targets. The reports included financial performance information which has assisted the Board of Directors with their financial decisions. The monthly information provided to the Board of Directors has been similar to the primary statements within these accounts.

The Board of Directors have received financial information relating to operating segments in the form of analysis of variances against budget. The analysis focusses on variances to budget and does not provide details of total income and expenditure by operating segment. As this analysis is not in a suitable format to be reconciled to the Trust's income and expenditure per the Statement of Comprehensive Income, the information has not been included within these Accounts.

3. Income from activities

	2021/22	2020/21
	£000	£000
Block contract / system envelope income*	**417,432**	366,586
High cost drugs and devices income from commissioners	**71,901**	62,295
Other NHS clinical income	**1,692**	1,232
Private patient income	**950**	478
Other clinical income - non-recurring annual leave and overtime funding	**-**	6,065
Elective Recovery Fund	**25,171**	-
Community services income from CCGs and NHS England and Devon County Council	**59,940**	58,428
Additional pension contribution central funding**	**17,117**	16,337
	594,203	511,421

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of 2020/21 and in 2021/22, 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 employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration 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.

3.1 Income from activities - by source

	2021/22	2020/21
	£000	£000
NHS England	**152,822**	139,864
Clinical commissioning groups	**438,738**	370,122
NHS trusts	**949**	225
Local authorities	**1**	11
Non-NHS - private patients	**667**	389
Non-NHS - overseas patients (non-reciprocal)	**283**	89
NHS injury scheme	**538**	586
Non-NHS - other	**205**	135
	594,203	511,421

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 based upon historical experience.

NOTES TO THE ACCOUNTS

3.2 Income from overseas visitors

	2021/22 £000	2020/21 £000
Income recognised this year	**283**	89

4. Other operating income

	2021/22 £000	2020/21 £000
Research and development	**23,945**	20,710
Education and training	**17,260**	16,347
Charitable and other contributions to expenditure	**173**	2,249
Non-patient care services to other bodies	**31,877**	29,468
Staff recharges	**4,930**	4,614
Reimbursement and top up funding *	**11,989**	59,830
Support from the Department of Health and Social Care for mergers	**750**	-
Rental revenue from operating leases	**5**	5
Other income	**11,805**	12,108
	102,734	145,331

Included within "Non-patient care services to other bodies" are laundry / decontaminations services, transport services, payroll services, IT services, audit services, diagnostic services, GP trainee income and drug and pharmacy sales totalling £26.3 million (2020/21 - £23.8 million). Better Care Funding of £3.1 million (2020/21 - £2.9million) is also included in this category. In 2020/21 Winter funding of £1.5m was also included in this category (£nil in 2021/22).

Included within "Other income" above is catering income of £1.9 million, (2020/21 - £1.4 million), car parking income of £0.8 million (2020/21 - £0.3 million), nursery/crèche income of £1.2m (2020/21 - £1.1 million), staff accommodation £0.5 million (2020/21 - £0.5 million), contributions to expenditure consumables (inventory/equipment) donated from DHSC group bodies £1.2m (2020/21 - £5.8m) as well as Charity recharges £0.9 million (2020/21 - £0.1 million), National Clinical Excellence Awards income £0.5 million (2020/21 - £0.3 million) and Urgent Community Response funding £0.9 million (2020/21 - £0.1 million).

* Reimbursement and top up funding includes the reimbursement of COVID-19 costs such as testing and vaccinations. In 2020/21 this category also included Nightingale site costs and top-up relating to the first six months of 2020/21.

5. Operating expenses

	2021/22 £000	2020/21 £000
Services from NHS and DHSC bodies	**3,513**	4,240
Services from non-NHS and non-DHSC bodies	**8,378**	8,128
Employee expenses - executive directors (see note 5.1)	**765**	843
Employee expenses - executive directors recharged to NDHT (included in income)	**766**	504
Employee expenses - non-executive directors (see note 5.1)	**130**	120
Employee expenses - non-executive directors recharged to NDHT (included in income)	**25**	28
Employee expenses - staff	**400,214**	380,507
Drug costs	**75,669**	66,481
Supplies and services - clinical (excluding drug costs)	**62,555**	56,929
Supplies and services - general	**6,384**	7,639
Establishment	**11,051**	9,268
Research and development - not included in employee expenses	**17,527**	14,203
Research and development - included in employee expenses (see note 6.1)	**5,710**	5,319
Education and training - not included in employee expenses	**1,553**	2,472
Education and training - included in employee expenses (see note 6.1)	**15,707**	13,882
Transport	**3,122**	2,623
Premises	**18,033**	38,451
Increase in bad debt provision	**28**	63
Depreciation	**14,967**	11,595
Amortisation of intangible assets	**5,989**	1,364
Impairments - buildings	**9,776**	-
Impairments - intangibles	**-**	18,594
Audit fees - statutory audit	**95**	84
Non-audit fee - audit related assurance services	**-**	-
Internal audit fees	**266**	266
Clinical negligence - amounts payable to NHSLA (premiums)	**14,853**	13,125
Losses, ex gratia and special payments - staff costs	**42**	-
Losses, ex gratia and special payments - non staff costs	**241**	102
Consultancy	**714**	1,402
Other	**13,711**	9,588
	691,784	667,820

"Other expenditure" above includes operating lease expenditure and patient travel.
The total employer's pension contributions are disclosed in note 6.1.

NOTES TO THE ACCOUNTS

5.1 Directors' remuneration and other benefits

	2021/22 £000	2020/21 £000
Aggregate directors' remuneration	**1,593**	1,376
Employer's contribution to pension scheme	**93**	119
Total	**1,686**	1,495

In the year ended 31 March 2022 five directors accrued benefits under defined benefit pension schemes (2020/21 - seven).

5.2 Auditor's remuneration

The audit fee, which includes statutory audit and quality accounts, was £95,000 in 2021/22 (2020/21 - £84,000), this includes £5,000 for the audit of the Trust's general charity.

5.3 Auditor's liability

The Board of Governors has appointed KPMG LLP as external auditors. The engagement letter signed on the 3rd June 2020 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed 125% of the annual fee in the aggregate in respect of all services (2019/20 - 125% of the annual fee).

5.4 Operating leases

	2021/22 £000	2020/21 £000
Operating lease payments recognised in expenses	**8,155**	6,041

Lease expenditure relates to minimum lease payments and is charged to the Statement of Comprehensive Income in a straight line basis over the term of the lease.

5.5 Future aggregate minimum lease payments due under non-cancellable operating leases are as follows:

	2021/22			2020/21		
	Land and buildings £000	**Other £000**	**Total £000**	Land and buildings £000	Other £000	Total £000
No later than 1 year	**5,407**	**1,564**	**6,971**	4,186	1,439	5,625
Later than 1 year and no later than 5 years	**21,425**	**2,978**	**24,403**	16,742	2,094	18,836
Later than 5 years	**32,965**	**1,706**	**34,671**	14,705	126	14,831
	59,797	**6,248**	**66,045**	35,633	3,659	39,292

NOTES TO THE ACCOUNTS

6. Staff costs and numbers

6.1 Staff costs

	2021/22 £000	2020/21 £000
Salaries and wages	**324,630**	316,945
Social security costs	**30,430**	27,955
Apprenticeship levy	**1,601**	1,503
Employer contributions to NHSPA	**56,447**	53,870
Termination benefits	**67**	148
Agency and contract staff	**10,610**	8,152
	423,785	408,573
Costs capitalised as part of assets	**315**	7,252
	423,470	401,321
Analysed into operating expenses (see note 5):		
Employee expenses staff	**400,256**	380,507
Employee expenses executive directors	**765**	843
Employee expenses - executive directors recharged to NDHT (included in income)	**766**	504
Research and development	**5,710**	5,319
Education and training	**15,707**	13,882
Internal Audit staff costs	**266**	266
	423,470	401,321

6.2 Average number of persons employed including directors

	Permanent employees Number	Other employees Number	2021/22 Total Number	2020/21 Total Number
Medical and dental	930	18	**948**	921
Ambulance staff	2	-	**2**	2
Administration and estates	1,452	107	**1,559**	1,600
Healthcare assistants and other support staff	2,494	294	**2,788**	2,755
Nursing, midwifery and health visiting staff	2,121	90	**2,211**	2,123
Scientific, therapeutic, technical and healthcare science staff	990	23	**1,013**	979
Other	13	-	**13**	15
Total	**8,002**	**532**	**8,534**	8,395

6.3 Staff exit packages

Exit package cost	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Less than £10,000	**24**	**75**	8	34
£10,000 to £25,000	**1**	**13**	2	24
£25,001 to £50,000	**1**	**29**	2	77
£50,001 to £100,000	**1**	**57**	-	-
£100,001 to £150,000	**-**	**-**	1	101
Total number	**27**	**174**	13	236

Exit packages relate to staff redundancies and payments in lieu of notice and include employer's NIC.

7. Pensions

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.

NOTES TO THE ACCOUNTS

7. Pensions (continued)

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.

8. Retirements due to ill-health

During 2021/22 there were eleven (2020/21 - two) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £933,000 (2020/21 - £110,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9. The late payment of commercial debts (Interest) Act 1998

In 2020/21 the Trust incurred less than £1k (2020/21 - less than £1k) arising from claims made under this legislation. The total liability accruing as a result of late payments is £nil (2020/21 £nil).

10. Finance income

	2021/22 £000	2020/21 £000
Interest on cash and cash equivalents	**32**	20

11. Finance expense

	2021/22 £000	2020/21 £000
Loans from the Independent Trust Financing Facility	**407**	467
Other loans	**2,124**	290
Finance leases	**74**	-
Unwinding of discount on provisions	**(4)**	(1)
Total	**2,601**	756

12. Other gains / (losses)

	2021/22 £000	**2020/21 £000**
Gains on disposal of assets	**15**	9
Losses on disposal of assets	**(1)**	-
Total	**14**	9

13. Better Payment Practice Code

	2021/22 Number	**2021/22 Value £000**	2020/21 Number	2020/21 Value £000
Total non-NHS trade invoices paid in the year	**143,559**	**353,591**	129,104	365,506
Total non-NHS trade invoices paid within target	**132,031**	**327,232**	116,274	333,254
Percentage of non-NHS trade invoices paid within target	**92.0%**	**92.5%**	90.1%	91.2%
Total NHS trade invoices paid in the year	**3,232**	**41,512**	3,635	31,771
Total NHS trade invoices paid within target	**2,790**	**36,268**	2,824	26,133
Percentage of NHS trade invoices paid within target	**86.3%**	**87.4%**	77.7%	82.3%

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

NOTES TO THE ACCOUNTS

14. Losses and special payments

	2021/22 Number	2021/22 Value £000	2020/21 Number	2020/21 Value £000
Losses:			Restated	Restated
Cash losses	**6**	**4**	4	1
Bad debts and claims abandoned	**42**	**27**	43	37
Stores losses, including damage to buildings	**2**	**98**	1	32
Total losses	**50**	**129**	48	70
Special payments - Ex-gratia	**69**	**155**	36	1,881
Total losses and special payments	**119**	**284**	84	1,951

Prior year ex-gratia payments have been re-stated to include £1.8m payments relating to the Flowers legal case settlement, for which NHS England obtained approval from HMT nationally on behalf of local employers. This case ruled on the treatment of overtime payments and in particular payments for voluntary overtime in the calculation of holiday pay and the interpretation of the Working Time Directive. Joint negotiations between NHS employers and NHS trade unions during 2021 agreed that a corrective payment would be made to those staff affected. Guidance was issued asking Trusts to accrue the cost of the nationally agreed corrective payments and associated income based on nationally generated estimates, and accordingly £1.8m was accrued within the 2020/21 accounts.

These payments were considered special payments, for which HMT approval was sought nationally by NHS England on Trusts' behalf. As the losses and special payments note is prepared on an accruals basis (excluding provisions), these amounts should have been disclosed within this note in the 2020/21 accounts. The Trust has therefore restated the prior year comparative to disclose these payments.

15. Intangible assets

15.1 Intangible assets at 31 March 2021

	IT In-house and 3rd party software £'000	Software licences £'000	Total £000
Fair value at 1 April 2020	-	2,138	2,138
Additions - purchased	26,663	540	27,203
Transferred into use - from property, plant and equipment (note 16.2)	34,625	-	34,625
Impairments	(18,594)	-	(18,594)
Disposals	-	(62)	(62)
Fair value at 31 March 2021	**42,694**	**2,616**	**45,310**
Accumulated amortisation at 1 April 2020	-	1,873	1,873
Provided during the year	1,238	126	1,364
Eliminated on disposals	-	(62)	(62)
Accumulated amortisation at 31 March 2021	**1,238**	**1,937**	**3,175**
Net book value			
Purchased at 31 March 2021	41,456	679	42,135
Total at 31 March 2021	**41,456**	**679**	**42,135**

The impairment charge of £18.6m in 2020/21 arose due to the fair valuation of the Trust's Health Record System.

15.2 Intangible assets at 31 March 2022

	IT In-house and 3rd party software £'000	Software licences £'000	Total £'000
Fair value at 1 April 2021	42,694	2,616	45,310
Additions - purchased	1,011	85	1,096
Transferred into use - from property, plant and equipment (note 16.1)	13	-	13
Fair value at 31 March 2022	**43,718**	**2,701**	**46,419**
Accumulated amortisation at 1 April 2021	1,238	1,937	3,175
Provided during the year	5,853	136	5,989
Accumulated amortisation at 31 March 2022	**7,091**	**2,073**	**9,164**
Net book value			
Purchased at 31 March 2022	36,627	628	37,255
Total at 31 March 2022	**36,627**	**628**	**37,255**

16. Property, plant and equipment

16.1 Property, plant and equipment at the statement of financial position date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	9,914	206,973	2,380	16,413	78,267	1,684	18,012	45	333,688
Additions - purchased	-	11,153	-	33,610	6,947	57	2,792	45	54,604
Additions - donated	-		-	-	173	-		-	173
Reclassifications - net total transferred to Intangible assets (note 15.2)	611	19,191	-	(21,235)	260	56	1,095	9	(13)
Impairment	-	(9,776)	-	-	-	-	-	-	(9,776)
Revaluation	-	1,054	-	-	-	-	-	-	1,054
Transfers to / from assets held for sale	(655)	(1,674)	-	-	-	-	-	-	(2,329)
Disposals	-	-	-	-	(100)	-	-	-	(100)
Total at 31 March 2022	**9,870**	**226,921**	**2,380**	**28,788**	**85,547**	**1,797**	**21,899**	**99**	**377,301**
Accumulated depreciation at 1 April 2021	-	6,314	125	-	44,292	1,270	11,168	45	63,214
Provided during the year	-	7,626	125	-	4,883	102	2,229	2	14,967
Transfers to / from assets held for sale	-	(14)	-	-	-	-	-	-	(14)
Eliminated on disposals	-	-	-	-	(97)	-	-	-	(97)
Accumulated depreciation at 31 March 2022	**-**	**13,926**	**250**	**-**	**49,078**	**1,372**	**13,397**	**47**	**78,070**
Purchased at 31 March 2022	9,870	209,025	2,130	28,788	34,597	425	8,473	52	293,360
Donated at 31 March 2022	-	3,970	-	-	1,872	-	29	-	5,871
Total at 31 March 2022	**9,870**	**212,995**	**2,130**	**28,788**	**36,469**	**425**	**8,502**	**52**	**299,231**

At the statement of financial position date there was one asset held under a finance lease, at a value of £1.8 million (2020/21 £2.0m). There were no assets held under hire purchase contracts or private finance initiative (PFI).

During the year the Trust has re-purposed the Exeter Nightingale Hospital to provide greater theatre and diagnostics capacity to the wider Devon healthcare system. This re-purpose of the building was supported by NHSEI, with the Trust receiving PDC Capital funding to meet the costs of the reconfiguration. The Trust's specialised buildings are valued using the depreciated replacement cost method, based upon providing a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. An impairment charge of £9.8m has arisen as the cost to retro-fit a building is higher than it would be to construct a new building. An impairment valuation was undertaken by Gerald Eve, who are professionally qualified valuers, and was in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual, International Financial Reporting Standards and it also complies with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings that would give the same service potential as is provided by the actual estate that the Trust owns, note 16.3 provides further details.

16. Property, plant and equipment (continued)

16.2 Property, plant and equipment at the statement of financial position date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	T
	£000	£000	£000	£000	£000	£000	£000	£000	£
Cost or valuation at 1 April 2020	9,914	163,975	2,380	49,997	59,612	1,600	13,410	45	300
Additions - purchased	-	19,855	-	19,836	12,797	84	3,293	-	55
Additions - donated	-	20	-	-	2,200	-	29	-	2
Reclassifications - net total transferred to Intangible assets (note 15.1)	-	13,655	-	(53,420)	3,860	-	1,280	-	(34,
Revaluation	-	9,468	-	-	-	-	-	-	9
Disposals	-	-	-	-	(202)	-	-	-	(
Total at 31 March 2021	**9,914**	**206,973**	**2,380**	**16,413**	**78,267**	**1,684**	**18,012**	**45**	**333**
Accumulated depreciation at 1 April 2020	-	-	-	-	40,792	1,170	9,801	45	51
Provided during the year	-	6,314	125	-	3,689	100	1,367	-	11
Eliminated on disposals	-	-	-	-	(189)	-	-	-	(
Accumulated depreciation at 31 March 2021	**-**	**6,314**	**125**	**-**	**44,292**	**1,270**	**11,168**	**45**	**63**
Purchased at 31 March 2021	9,914	196,539	2,255	16,413	31,039	414	6,811	-	263
Donated at 31 March 2021	-	4,120	-	-	2,936	-	33	-	7
Total at 31 March 2021	**9,914**	**200,659**	**2,255**	**16,413**	**33,975**	**414**	**6,844**	**-**	**270**

At the statement of financial position date there was one asset held under a finance lease, at a value of £2.0 million (2019/20 £Nil). There were no assets held under hire purchase contracts or private finance initiat (PFI).

During the year the Trust purchased the site of the Exeter Nightingale Hospital. In accordance with the Trust's Accounting Policy the asset has subsequently been revalued by professional valuers when brought use. The valuation was undertaken by Gerald Eve, who are professionally qualified valuers, and was in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual International Financial Reporting Standards and it also complies with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings that would give the same se potential as is provided by the actual estate that the Trust owns, note 16.3 provides further details.

NOTES TO THE ACCOUNTS

16. Property, plant and equipment (continued)

16.3 Revaluation of land, buildings and dwellings

Two properties were identified for disposal within 2021/22, these properties were revalued to their market value and re-classed as non-current assets held for sale prior to their disposal. This resulted in a revaluation gain of £1.1m. Other than the two properties disposed of and the Exeter Nightingale Hospital, there were no other valuations of the Trust's land, buildings and dwellings was required as at the 31 March 2021 or 31 March 2022. The last full valuation was as at 31 March 2020, and this valuation is still considered to be appropriate, based upon the movement in the BCIS indices, and after reviewing for any impairment. The Trust's specialised buildings and associated land were valued using the depreciated replacement cost method, based upon providing a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. The valuation of the Trust's specialised land and buildings was therefore based upon the Trust hypothetically being located on a suitable alternative site away from the city centre, where the cost of the land would be significantly lower, but where the Trust would still be able to re-provide its services.

During the pandemic the Trust was the regional host for the Nightingale Hospital. In 2020/21 the Trust's Board of Directors, with the support of NHSEI, agreed to purchase the site of the Exeter Nightingale Hospital. This decision was based upon undertaking appropriate due diligence and it was assessed that purchasing the site offered best value for money. In accordance with the Trust's Accounting Policy the asset was subsequently revalued by professional valuers when brought into use and the revaluation recognised an uplift of £9.5m as at 31 March 2021. In 2021/22 the Exeter Nightingale Hospital was re-purposed to provide greater theatre and diagnostics capacity to the wider Devon healthcare system. This re-purpose of the building was supported by NHSEI, with the Trust receiving PDC Capital funding to meet the costs of the reconfiguration. An impairment charge of £9.8m has arisen as the cost to retro-fit a building is higher than it would be to construct a new building. Valuations as at the 31 March 2021 and 31 March 2022 were both undertaken by Gerald Eve, who are professionally qualified valuers, and were in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual, International Financial Reporting Standards complying with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings, in line with the last full valuation in March 2020, that would give the same service potential as is provided by the actual estate that the Trust owns.

17. Investments in associates and joint ventures

	31 March 2022	31 March 2021
	£000	£000
Carrying value at 1 April	**5**	5
Carrying value at 31 March	**5**	5

In 2016/17 the Trust acquired a 20% shareholding in a new company Dextco Limited. Dextco Limited is a joint venture between the Trust and a number of local public sector bodies with the aim of developing energy projects in Exeter.

18. Inventories

18.1 Inventories held at year end

	31 March 2022	31 March 2021
	£000	£000
Drugs	**1,938**	1,990
Consumables	**7,770**	8,331
Energy	**238**	232
Inventories carried at fair value less costs to sell	**285**	248
Total inventories	**10,231**	10,801

NOTES TO THE ACCOUNTS

18.2 Inventories recognised in expenses

	2021/22 £000	2020/21 £000
Inventories recognised in expenses	**92,644**	73,487
Write-down of inventories recognised in expenses	**98**	190
Total inventories recognised in expenses	**92,742**	73,677

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,077,000 of items purchased by DHSC (2020/21 £5,528,000).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

19. Trade and other receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	**31,457**	16,089
Prepayments	**4,984**	5,227
Allowance for impaired contract receivables / assets	**(656)**	(628)
Other receivables	**287**	463
PDC dividend receivable	**-**	311
VAT receivable	**905**	2,943
Total current trade and other receivables	**36,977**	24,405
Non-current		
Contract receivables	**1,364**	1,322
Other receivables	**590**	1,273
Total non-current trade and other receivables	**1,954**	**2,595**
Total trade and other receivables	**38,931**	27,000

Provision for impairment of receivables	31 March 2022 £000	31 March 2021 £000
At 1 April	**628**	565
Increase in provision	**(96)**	(78)
Amounts utilised	**124**	141
At 31 March	**656**	628

The provision for impairment of receivables relates to specific receivables over 3 months old.

19.1 Ageing of impaired financial assets

	31 March 2022 Trade and other receivables £000	31 March 2021 Trade and other receivables £000
0 - 30 days	**-**	-
30 - 60 Days	**-**	-
60 - 90 days	**-**	-
90 - 180 days	**1,013**	1,705
Over 180 days	**3,599**	4,431
	4,612	6,136

19.2 Ageing of non-impaired financial assets past their due date

0 - 30 days	**1,370**	703
30 - 60 days	**539**	414
60 - 90 days	**506**	305
90 - 180 days	**829**	941
Over 180 days	**-**	-
	3,244	2,363

20.1 Current trade and other payables

	31 March 2022 £000	31 March 2021 £000
NHS payables	**4,164**	6,600
Trade payables - capital	**15,584**	11,849
Other trade payables	**3,652**	3,654
Other taxes payable	**8,286**	7,680
PDC dividend payable	**306**	-
Other payables	**5,666**	5,298
Accruals	**36,419**	34,576
	74,077	69,657
Other liabilities		
Other deferred income	**14,083**	9,009

NOTES TO THE ACCOUNTS

20.2 Non current other liabilities

	31 March 2022 £000	31 March 2021 £000
Other deferred income	**1,877**	1,959

21. Borrowings

Current

	31 March 2022 £000	31 March 2021 £000
Loans from Foundation Trust Financing Facility	**1,271**	1,270
Other Loans	**4,828**	4,587
Obligations under finance leases	**178**	172
	6,277	6,029

Non-current

Loans from Foundation Trust Financing Facility	**6,238**	7,509
Other Loans	**55,105**	56,750
Obligations under finance leases	**1,695**	1,873
	63,038	66,132
Total borrowings	**69,315**	72,161
Amounts falling due within:		
In one year or less by instalments	**6,277**	6,029
Between one and five years by instalments	**36,421**	40,711
Over five years by instalments	**26,617**	25,421
	69,315	72,161

Foundation Trust Financing Facility

Two loans are repayable to the Secretary of State for Health and Social Care. The first loan of £17 million, was entered into in the year ended 31 March 2006. It is repayable over a 20 year period, ending 30 March 2026, by equal quarterly instalments and the interest rate of the loan is fixed at 4.55% per annum. The second loan of £10 million, was entered into in the year ended 31 March 2007, and is repayable over a 25 year period, ending 30 March 2032, by equal quarterly instalments and the interest rate of the loan is fixed at 5.05% per annum.

Other loans

Loans of £21m were received from both Hitachi Capital and Siemens Bank in the year ended 31 March 2019. The loans are repayable over a 12 year period ending September 2030, in equal quarterly instalments commencing December 2020.

A loan of £16.9m has been received from a supplier (received between 2018/19 and 2021/22). The loan is repayable over an 11 year period ending March 2029.

A loan of £6.2m has been received from Salix (received in 2019/20 and 2021/22). The loan is repayable over a 7 year period ending October 2027.

	Loans from DHSC £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2021	8,779	61,337	2,045	72,161
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,270)	(1,963)	(172)	(3,405)
Financing cash flows - payments of interest	(407)	(1,566)	(74)	(2,047)
Non-cash movements:				
Application of effective interest rate	407	2,124	74	2,605
Other changes	-	1	-	1
Carrying value at 31 March 2022	**7,509**	**59,933**	**1,873**	**69,315**

22. Provisions

	Early retirements £000	Legal claims £000	Injury benefits £000	Other £000	Total £000
At 1 April 2021	57	225	311	1,396	**1,989**
Arising during the year	(16)	60	25	-	**69**
Utilised during the year	(5)	(73)	(17)	-	**(95)**
Reversed unused	-	(46)	-	(803)	**(849)**
Unwinding of discount	(1)	-	(3)	-	**(4)**
At 31 March 2022	**35**	**166**	**316**	**593**	**1,110**

Expected timing of cash flows:

	31 March 2022 £000	31 March 2021 £000
In one year or less	**191**	372
Between one and five years	**93**	240
Over five years	**826**	1,377
	1,110	1,989

Legal claims relate to employee and public liability claims.

Contingent liabilities relating to legal claims are shown in note 25.

NHS Resolution is carrying provisions as at 31 March 2022 in relation to Existing Liabilities Scheme and in relation to Clinical Negligence Scheme on behalf of the Trust of £325.2m (2020/21 - £207.2m).

Other provisions relate to the estimated clinicians' pension tax. An equal amount due from NHSE is included in Receivables.

NOTES TO THE ACCOUNTS

23. Cash and cash equivalents

	31 March 2022 £000	31 March 2021 £000
At 1 April 2021	**63,543**	58,081
Net change in the year	**5,032**	5,462
At 31 March 2022	**68,575**	63,543
Broken down into:		
Cash at commercial banks and in hand	**24**	25
Cash with Government Banking Service	**68,551**	63,518
Cash and cash equivalents as in SoFP and Cash Flow Statement	**68,575**	63,543

Cash and cash equivalents represents cash in hand and deposits with any financial institution with a short term maturity period of three months or less from the date of the acquisition of the investment.

24. Capital commitments

Commitments under capital expenditure contracts, which relate to property, plant and equipment, at the statement of financial position date were £7,044,000 (2020/21 - £7,408,000).

25. Contingent liabilities

	31 March 2022 £000	31 March 2021 £000
Contingent NHS Resolution legal claims	-	-

26. Related party transactions

The Trust is a public benefit corporation established under the NHS Act 2006. The Department of Health has the power to control the Trust and therefore can be considered to be the Trust's parent. The Trust's Accounts are included within the NHS Foundation Trust Consolidated Accounts, which are included within the Whole of Government Accounts. The Department of Health is accountable to the Secretary of State for Health. The Trust's ultimate parent is therefore HM Government.

The Trust is under the common control of the Board of Directors.

Directors' remuneration and other benefits are disclosed within the operating expenditure, note 5.1.

The Royal Devon and Exeter NHS Foundation Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity ("Charity"), registered charity number 1061384, registered office Newcourt House, Newcourt Road, Exeter, EX2 7JU. The Charity's objective is for any charitable purpose and purposes relating to the National Health Service wholly or mainly for the Royal Devon and Exeter NHS Foundation Trust. The Trust has received during the year £58,000 (2020/21 - £58,000) revenue income, £Nil grant income (2020/21 £Nil) and £173,000 (2020/21 - £110,000) capital contributions from the Charity. At 31 March 2022 the Trust was due £45,000 (2020/21 - £47,000) from the Charity. The Charity's most recent audited accounts were for the year ended 31 March 2021 and the Charity held aggregated reserves of £3,314,000.

During the year the Royal Devon and Exeter NHS Foundation Trust has had a significant number of material transactions with the Department of Health and Social Care ("DoHSC"), and with other entities for which the DoHSC is regarded as the parent of those entities. Income from activity - by source (note 3.1) and the operating expense (note 5) provides details of revenue transactions with those entities. Below are considered to be the significant material transactions.

	Income £000	Expenditure £000	Receivables £000	Payables £000
2021/22				
Department of Health (excludes PDC dividend)	**22,492**	**-**	**667**	**-**
Health Education England	**20,589**	**-**	**761**	**-**
NHS England (Includes Regional offices / Commissioning hubs)	**148,963**	**67**	**3,850**	**-**
NHS Devon CCG	**429,812**	**1,004**	**16,944**	**100**
NHS Somerset CCG	**5,318**	**-**	**-**	**-**
Northern Devon Healthcare NHS Trust	**7,663**	**1,889**	**203**	**350**
2020/21				
Department of Health (excludes PDC dividend)	19,168	-	1,221	-
Health Education England	19,517	-	741	-
NHS England (Includes Regional offices / Commissioning hubs)	186,814	63	4,384	2,225
NHS Devon CCG	359,085	389	952	259
NHS Somerset CCG	5,179	-	12	-
Northern Devon Healthcare NHS Trust	6,344	1,547	1,155	73

NOTES TO THE ACCOUNTS

27. Financial instruments

A financial instrument is a contract that gives rise to both a financial asset in one entity and a financial liability or equity instrument in another entity. IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period 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 arises when the Trust is exposed to the risk that a party is unable to meet its obligation to the Trust in respect of financial assets due.

Financial assets mainly comprise monies due from clinical commissioning groups (CCG) and NHS England for services rendered by the Trust in fulfilment of service agreements, and cash balances held on deposit. It is considered that financial assets due from these organisations pose a low credit risk as these entities are funded by HM Government.

A significant proportion of the Trust's cash balances are held on deposit with the Government Banking Service, and as such the credit risk on these balances is considered to be negligible.

Liquidity risk

Liquidity risk arises if the Trust is unable to meet its obligations arising from financial liabilities. The Trust's financial liabilities mainly arise from net operating costs, which are mainly incurred under legally binding annual service agreements with CCG and NHS England, and liabilities incurred through expenditure on capital projects. Other liquidity risks are loans repayable to the FTFF and commercial loan providers.

Income from contracted activities with CCG and NHS England are based upon a nationally set tariff, which under Payment by Results is paid to the Trust in twelve monthly instalments throughout the year; any performance in excess of agreed targets is paid in accordance with the terms of the relevant contract. Payment by instalments allows the Trust to accurately forecast cash inflows and through the preparation and review of cash flow forecasts, as well as the controls in place governing the authorisation of expenditure, ensures that the Trust maintains sufficient funds to meet obligations as they fall due.

Market risk

Market risk arises when the Trust is exposed to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

Currency risk

The Trust receives income denominated in sterling. The Trust, on occasion, does enter into agreements to make payments in non-sterling denominated currencies. Non-sterling payments are principally short term liabilities and for non-significant amounts. Given this, the Trust does not consider that it is exposed to any material currency risk and therefore has elected not to hedge its exposure.

Interest rate risk

The Trust does not enter into contracts where cash flows are determined by the use of a variable interest rate.

Other price risk

The Trust enters into legally binding contracts with both its customers and suppliers that stipulate the price to be paid. As such it does not consider itself exposed to material other price risk.

NOTES TO THE ACCOUNTS

27. Financial instruments (continued)

27.1 Carrying value of financial assets

	Held at amortised cost £000
Trade and other receivables excluding non financial assets	18,519
Cash and cash equivalents at bank and in hand	63,543
Total at 31 March 2021	82,062

	Held at amortised cost £000
Trade and other receivables excluding non financial assets	**33,023**
Cash and cash equivalents at bank and in hand	**68,575**
Total at 31 March 2022	**101,598**

An analysis of any impairment of financial assets is provided in note 19.1.

27.2 Carrying value of financial liabilities

	Held at amortised cost £000
Loans from the Department of Health and Social Care	8,779
Other borrowings	61,337
Obligations under finance leases	2,045
Trade and other payables excluding non financial liabilities	61,977
Total at 31 March 2021	134,138

	Held at amortised cost £000
Loans from the Department of Health and Social Care	**7,509**
Other borrowings	**59,933**
Obligations under finance leases	**1,873**
Trade and other payables excluding non financial liabilities	**65,466**
Total at 31 March 2022	**134,781**

NOTES TO THE ACCOUNTS

27.3 Fair value

For all of the financial assets and liabilities at 31 March 2022 and 31 March 2021 the fair value is equal to book value.

28. Third party assets

The Trust held £Nil cash at bank and in hand at 31 March 2022 (2020/21 - £4,880) relating to monies held on behalf of patients.

29. Accounting standards issued and not adopted

The accounts have been prepared in accordance with the 2021/22 Department of Health and Social Care Group Accounting Manual (GAM) issued by Department of Health. The accounting policies contained in that manual follow International Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. Below is a list of recent standards issued but not yet adopted in the NHS.

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 will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. 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:

Estimated impact on 1 April 2022 statement of financial position

	£000
Additional right of use assets recognised for existing operating leases	**55,482**
Additional lease obligations recognised for existing operating leases	**(55,482)**
Net impact on net assets on 1 April 2022	**-**

Estimated in-year impact in 2022/23

	£000
Additional depreciation on right of use assets	**(5,855)**
Additional finance costs on lease liabilities	**(457)**
Lease rentals no longer charged to operating expenditure	**5,989**
Estimated impact on surplus / deficit in 2022/23	**(323)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,303**

30. Events after the Balance sheet date

On the 1 April 2022, the Royal Devon and Exeter NHS Foundation Trust acquired the assets and business of the Northern Devon Healthcare NHS Trust forming the Royal Devon University Healthcare NHS Foundation Trust through merger by acquisition, approved by NHSEI. The two trusts have been working collaboratively for a number of years, and the merger will unlock further opportunities to improve care for patients across North, Mid and East Devon.